COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

November 8, 2004

MEMORANDUM

TO: All Interested Parties in Virginia's Dental Benefits Administrator Program – Virginia Smiles

FROM: Patrick W. Finnerty, Director
Virginia Department of Medical Assistance Services

SUBJECT: Review of "Draft" Request for Proposals (RFP-XXX) for a Virginia Medicaid/FAMIS Dental Benefits Administrator

Attached is the Department of Medical Assistance Services' (DMAS) initial "draft" Request for Proposals for a Medicaid/FAMIS Virginia Medicaid Dental Benefits Administrator Service Provider.

The purpose for publishing this "draft" is twofold. First, to provide you with the opportunity to see the direction the Department is proceeding with this program. And second, to provide you with the opportunity to provide general comments. However, due to the expedited RFP process, any general comments must be received **by 8:00 a.m. on Monday, November 15, 2004**. These comments should be sent to: va.smiles@dmas.virginia.gov. The release of the final RFP is scheduled for the last week in November 2004.

DMAS will not be able to respond to individual comments or questions at this time on the "draft" RFP. There will be the opportunity to raise questions at the Pre-Proposal conference.

Thank you for your continued interest in DMAS' new dental program. Please continue to check our website, www.dmas.virginia.gov, for any updates on the progress of this program.

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1. PURPOSE AND DEFINITIONS

The Department of Medical Assistance Services (DMAS) hereinafter referred to as the Department or DMAS, is the single State agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the State Child Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act for low-income people. These programs are financed by federal and state funds and administered by the state according to federal guidelines. Both programs include coverage of dental services for eligible Medicaid/FAMIS Plus and FAMIS enrollees.

The 2004 Appropriations Act, Item 322 H. (see Attachment IX) directs the Department to consolidate and administer dental services under a single, fee-for-service program. Therefore The Department is hereby soliciting proposals from qualified organizations through a competitive procurement process for a dental benefits administrator (DBA) to include coordination, management, and reimbursement of dental services. The Contract will be provided as an Administrative Services Only (ASO) Contract. These services are to provide eligible Title XIX Medicaid enrollees and Title XXI FAMIS children with dental services. This Request for Proposals (RFP) is for the provision of dental services statewide for Medicaid recipients and children enrolled in Virginia's Title XXI program (FAMIS). Dental services also are provided for recipients enrolled in Medicaid home-based and community-based waiver programs.

Number of Awards: An Offeror may submit a proposal for statewide services only. The maximum number of contracts to be awarded under this RFP is one. Based on the proposals, DMAS is planning to select and enter into a contractual agreement with a qualified organization for the provision of dental services in Commonwealth.

Duration of Contract: The duration of each contract resulting from this RFP is three years, with up to three one-year renewals at DMAS' option.

General Scope of Responsibilities: The responsibilities of the DBA, which are more fully described later in the RFP, will include expanding the Department's dental provider network, including recruiting, credentialing and contracting with providers; increasing enrollee utilization of dental services; handling prior authorization requests, processing claims and submitting encounter data; promoting the new dental program; conducting provider and enrollee outreach activities; handling enrollee and provider services issues; and interfacing with the Virginia Medicaid Management Information System (VAMMIS). The Commonwealth's goal is to increase access to and utilization of high quality dental care services through an expanded and adequate network of dental providers. The Contractor selected in response to this RFP must be able to perform the services described in the RFP's Section 4 Scope of Services, by **June 1, 2005.**

Dental services are currently covered for Medicaid/FAMIS Plus children under 21 years of age and under age 19 for FAMIS children. Covered services are defined as any medically necessary diagnostic, preventive, restorative, and surgical procedures, as well as orthodontic procedures,

administered by, or under the direct supervision of, a dentist. Limited medically necessary oral surgery coverage is available for enrollees 21 years of age and older when performed by a participating dentist and only when the service is one that is either generally covered under Medicare and/or is medically necessary. Examples of medically related covered services for adults include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses complicating a medical condition or contributing to poor general health.

Volume and Participation: Dental services are currently covered for approximately 420,000 Medicaid/FAMIS Plus and FAMIS children. Approximately 276,000 of these children (244,000 Medicaid/FAMIS Plus and 32,000 FAMIS) receive care through managed care organizations (MCOs). Approximately 144,000 of these children receive care through the Department's fee-for-service (FFS) program, where 135,000 are Medicaid/FAMIS Plus eligible enrollees and approximately 9,000 are eligible under FAMIS. Limited coverage for medically necessary oral surgery is available for approximately 200,000 Medicaid adults.

Department's Dental Program Name: The Department plans to promote the new delivery system that consolidates dental services for MCO and FFS enrollees under a unified dental administrative arrangement as *"Virginia Smiles."*

1.2 Definitions

Throughout this RFP, the following definitions are applicable:

The following terms when used in this RFP shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

1. Administrative Cost - All costs to the Contractor related to the administration of this RFP. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP (including, but not limited to, claims processing, postage, personnel, rent) are considered to be an "administrative cost."
2. Administrative Services Fee - The per member per month amount Contractor will charge for provision of the services outlined in this RFP.
3. Adverse Action - Any action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of covered benefits.
4. Annually – For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.
5. Appeal Procedure - The process to resolve an enrollee's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by the Department regulations and any and all applicable court orders. Complaint shall mean an enrollee's right to contest any other action taken by the Contractor or service provider other than those that meet the definition of an adverse action.

6. Benefits - A schedule of health care services to be delivered to enrollees covered in the Contractor's plan developed pursuant to Attachment 1 of this RFP.
7. Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.
8. Case Management – The process of identification of patient needs and the development, implementation, monitoring, and revising (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.
9. Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.
10. Clarification – A revision that is not a change or amendment to the RFP but is only a revision in language to more accurately reflect the existing contractual agreement between the parties. Such clarifications are housekeeping items only, and as such, bear an effective date of the RFP.
11. Claim – An itemized statement requesting payment for services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500, UB-92, and/or ADA Dental claim forms.
12. Clean claim - A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the Contractor.
13. Client, Recipient, Enrollee, Member or Participant - An individual having current Medicaid/FAMIS Plus or FAMIS eligibility who shall be authorized by the Department to participate in the dental program.
14. CMS - Centers for Medicare and Medicaid Services.
15. Contract - The signed and executed document resulting from this RFP.
16. Contract Modifications - Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.
17. Contractor - The entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide dental services, or to enhance the Department's capability for effective administration of the program.
18. Covered Service - Medically necessary dental services for Medicaid/FAMIS Plus children under 21 years of age and under age 19 for FAMIS children and limited medically necessary oral surgery for Medicaid eligible individuals over age 21.
19. Dental Benefits Administrator (DBA) - An entity that manages or directs a dental benefits program on behalf of the program's sponsor. For the purposes of this RFP and resulting contract, the DBA is responsible for administering the Department's dental benefits program statewide for Title XIX Medicaid recipients and Title XXI FAMIS children to include coordination, management, and reimbursement of such dental services.
20. Department - The Virginia Department of Medical Assistance Services.
21. Disenrollment - The discontinuance of a enrollee's entitlement to receive covered services under the terms of this RFP, and deletion from the approved list of enrollees furnished by the Department to the Contractor.
22. Eligible Person - Any person certified by the Department as eligible to receive services and benefits under the Department's Program.

23. Emergency Dental Condition – A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissues; or unusual swelling of the face and gums.
24. Emergency Medical Services (or Emergency Services) – Covered dental services furnished by a qualified participating or nonparticipating provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.
25. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.
26. Encounter – Any covered service received by an enrollee and processed by the Contractor.
27. Encryption – A security measure process involving the conversion of data into a format that cannot be interpreted by outside parties.
28. Enrollee, Client, Recipient, Member or Participant - An individual having current Medicaid/FAMIS Plus or FAMIS eligibility who shall be authorized by the Department to participate in the dental program.
29. Enrollee Month - A month of health care coverage for an enrollee.
30. Enrollment - The process by which a person becomes an enrollee of the Contractor's plan through the Department.
31. EPSDT - The Early and, Periodic, Screening, Diagnosis, and Treatment services mandated by 42U.S.C. § 1396d(e) and amended by OBRA 1989. By statute, the State "must provide or arrange for" four separate screens: medical, vision, hearing and dental.
32. FAMIS Enrollee - means persons enrolled in the Department' FAMIS program who are eligible to receive dental services under the State Child Health Plan under Title XXI, as amended.
33. FAMIS Plus Enrollees – Children under the age of 19 who meet "medically indigent" criteria under Medicaid program rules, and who are assigned an aid category code of 90; 91 (under 6 years of age); 92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost sharing responsibilities. Additionally, for the terms set forth in this Contract, FAMIS Plus and Medicaid enrollees shall be treated in the same manner. Any information sent to FAMIS Plus and Medicaid enrollees must appropriately address the entire intended population. For example, enrollment and benefit materials cannot specify "Medicaid" unless they also specify "FAMIS Plus." If the material does not specify "Medicaid," it does not need to specify "FAMIS Plus."
34. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this RFP; or (b) maintained by a subcontractor or provider to provide services on behalf of the Contractor.
35. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment for defined services.
36. Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.
37. Fiscal Year (State) – July 1 through June 30.

38. Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.
39. FTE - Full time equivalent position.
40. Grievance – An expression of dissatisfaction by the enrollee about any action taken by the Contractor or service provider other than an adverse action as adverse action is defined in this RFP. The Contractor shall not treat anything as a grievance that falls within the definition of adverse action.
41. Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.
42. Inquiry – An oral or written communication usually received by an Enrollee or Member Services Department or telephone help line representative made by or on the behalf of an enrollee that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received, etc.; 2) provision of information regarding a change in the enrollee's status such as address, family composition, etc.; or; 3) a request for assistance such as selecting or changing a provider, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.
43. Managed Care Organization ("MCO") - An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Medallion II program.
44. Marketing - Any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade eligible persons to utilize their covered dental services and to be aware of the services offered by the Contractor pursuant to this RFP.
45. Marketing Materials - Any materials that are produced in any medium, by or on behalf of the Contractor; are used by the Contractor to communicate with individuals about the Department's dental program benefits and services.
46. Medicaid Management Information System (MMIS) - The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.
47. Medicaid Enrollee - An individual having current Medicaid eligibility who shall be authorized by the Department to participate in the dental program.
48. Medical Record - A single complete record kept at the site of the enrollee's treatment(s), which documents all of the treatment plans developed, medical services ordered for the enrollee and medical services received by the enrollee.
49. Medically Necessary - Services or supplies provided by an institution, physician, or other provider that are required to identify or treat an enrollee's illness, disease, or injury and which are:

    a Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, or injury; and
    b Appropriate with regard to standards of good dental practice; and
    c Not solely for the convenience of an enrollee, dentist, physician, institution or other provider; and

d The most appropriate (in terms of cost and effectiveness) supply or level of service that can safely be provided to the enrollee and that is sufficient in amount, duration, or scope to reasonably achieve their purpose. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and

e When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

50. Member - See enrollee.

51. Monthly – For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

52. Network Provider - The health care entity or health care professional who is either employed by or has executed an agreement with the Contractor, or its subcontractor, to render covered services, as defined in this Contract, to enrollees.

53. Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or through the Contractor or any of its subcontractors pursuant to the RFP between the Contractor and the Department.

54. Out-of-Plan Services - Services provided by a non-contract provider.

55. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

56. Primary Care Provider - A primary care physician or nurse practitioner or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

57. Prior Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.

58. Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

59. Provider - An institution, facility, agency, person, corporation, partnership, or association approved by the Department which accepts as payment in full for providing benefits the amounts paid pursuant to a provider RFP with the Contractor.

60. Provider Agreement - An agreement between a Dental Benefits Administrator (DBA) and a provider or DBA's subcontractor and a provider of oral health care services which describes the conditions under which the provider agrees to furnish covered services to DBA's enrollees.

61. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical/dental knowledge.
62. Quarterly – For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter, unless otherwise specified by the Department.
63. Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.
64. Recipient, Member, Enrollee, Client, or Participant - An individual having current Medicaid/FAMIS Plus or FAMIS eligibility who shall be authorized by the Department to participate in the dental program.
65. Rural Health Clinic - A facility as defined in 42 C.F.R. § 491.2, as amended.
66. Service Location - Any location at which an enrollee obtains any oral health care service covered by the Contractor pursuant to the terms of this RFP.
67. Service Site - The locations designated by the Contractor at which enrollees shall receive oral health treatment and preventive services.
68. Services - The benefits described in Attachment I
69. Shall - Indicates a mandatory requirement or a condition to be met.
70. Specialty Services – Includes Pediatric Dentistry, Oral Surgery, Endodontics, Periodontics and Orthodontics.
71. State - Commonwealth of Virginia.
72. State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.
73. Subcontract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this RFP. Agreements to provide covered services as described in Attachment I of this RFP shall be considered Provider Agreements and governed by Section XX of this RFP.
74. Subcontractor - Any State approved organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP. For the purposes of this Contract, the subcontractor's providers shall also be considered providers of the Contractor.
75. Third Party Resource - Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical/dental care of the enrollee.
76. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party.

77. Urgent Dental Condition – A dental or oral condition that requires services for relief of symptoms and stabilization of the condition within a reasonable period of time, as determined by the treating dentist, other dental professional, primary care provider, or triage nurse who is trained in dental care and oral care. Such conditions may include minor tooth fracture; an oral tissue lesion that is visible to the enrollee; and lost restoration.
78. Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.
79. Virginia Smiles – The Department's product name for the Medicaid/FAMIS dental program that consolidates dental services for MCO and FFS enrollees under a unified dental administrative arrangement.

2. BACKGROUND

Dental services are a mandatory Medicaid benefit for children. Section 1902(a)(43) of the Social Security Act specifically requires that State Medicaid plans provide or arrange for such services. In addition, The Virginia State Plan for FAMIS, as provided for in the *Code of Virginia* § 32.1-320, as amended includes provisions for dental benefit coverage for FAMIS children.

Currently the Department contracts with seven MCOs for the provision of most Medicaid/FAMIS Plus and FAMIS covered services. Each MCO may handle the provision of dental services to its enrollees in a different way, (e.g., direct contracting, use of subcontractors, etc.). Subcontracts and/or provider agreements with dental providers are currently the responsibility of the MCOs, as are responsibilities for dental prior authorization and claims adjudication and payment functions. The Department utilizes an outside vendor to handle dental prior authorizations for FFS enrollees under age 21, while prior authorization for adults and claims adjudication and payment functions are handled in-house and/or through the Department's Fiscal Agent.

Table 1 captures Virginia Medicaid dental utilization data from the Centers for Medicare and Medicaid Services' (CMS) "416 Report" and categorizes by age, Virginia Medicaid enrollees who are eligible for the EPSDT dental program and their approximate utilization of any services. The report reveals that for federal fiscal year (FFY) 2001-2002 approximately 339,496 Medicaid enrollees over the age of three and under the age of 21years were eligible for dental services. This was an increase of 4.5% in the number of eligible enrollees from FFY 2000-2001. However, based on this report, dental utilization decreased by 4 percentage points for total eligibles receiving dental services, from 27% in the previous annual reporting period to 23% in the FFY 2002. (The CMS 416 report provides basic information on participation in the Medicaid child health program, including receipt of dental services.)

This table represents combined data from FFS Medicaid and Medicaid MCOs. The percentage of Virginia Medicaid children receiving dental services is generally comparable to many other states. As indicated by Table 1, there has been a decrease in the dental utilization from fiscal year 2001 to fiscal year2002 and the percentage of Medicaid children receiving dental care remains quite low and needs to improve

Table 1: Virginia Pediatric Dental Utilization *

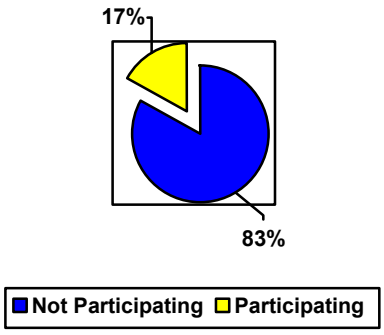
Age Categories	Total Individuals Eligible		Total Eligibles Receiving Any Dental Services		% Utilization	
	FFY 2001	FFY 2002	FFY 2001	FFY 2002	FFY 2001	FFY 2002
3 to 5	69,213	71,987	17,937	16,314	25.92%	22.83%
6 to 9	82,452	83,312	25,693	22,184	31.16%	26.63%
10 to 14	90,885	97,678	27,259	24,896	29.99%	25.49%
15 to 18	56,307	60,742	14,154	13,314	25.14%	21.92%
19 to 20	25,291	25,777	2,979	2,598	11.78%	10.08%
Total	**324,148**	**339,496**	**88,022**	**79,306**	**27.15%**	**23.36%**

* Excludes FAMIS children (approximately 40,000 children)

Unfortunately, Medicaid efforts to date to increase provider participation in the program have not yielded significant results. Reasons for non-participation most commonly cited by Virginia dental providers include: reimbursement rates for providers, workforce issues, administrative complexities, and client issues such as education, outreach and case management for broken appointments.

Low participation of Virginia dentists continues to be a problem as illustrated in Figure 1. Virginia has approximately 4,800 licensed dental providers. Approximately 800 (17%) of the Virginia licensed dental providers participate in the Medicaid and FAMIS programs.

Figure 1: Dental Provider Participation in Virginia Medicaid/FAMIS



The lack of access is especially critical among low-income children served by the Medicaid and the FAMIS programs. Central to the issue of poor access to dental services for low-income children is the method of delivering dental services. In 1996, the Department started moving its clients into MCOs. Early indications reflect that this move increased access to dental services. However, over the last year, the Department has received complaints from the dental provider community that the administrative burden associated with multiple payer contracts (i.e., multiple MCOs and the Department's FFS program) combined with the issue of low provider reimbursement, further deters provider participation in the program. Collaborative discussions between the Department, the Department's Dental Advisory Committee (DAC) and the Virginia

Dental Association (VDA) have led to the recommendation that the Department carve dental services out of MCO contracts and consolidate dental services under a unified dental administrative arrangement.

2.1 Directives from the General Assembly

There has also been a growing recognition at the State level that an intervention strategy to improve access to dental services for all Virginians is warranted, but the need is especially acute for low-income children. The General Assembly directed the Joint Commission on Health Care (JCHC) to study dental care access in depth, and it directed the Department to take specific steps to increase dental access and utilization.

The legislature has repeatedly expressed its desire to see the dental access problem addressed through various directives that have requested different entities to identify the major issues and begin developing methods to address the problem.

2.2 The Department Reports to the General Assembly

In 1998, the General Assembly directed the Department to report on its efforts to expand the availability and delivery of dental services to pediatric Medicaid clients. The Department started submitting annual reports in 1998 to the General Assembly describing the status of access to dental services for Medicaid children. Reports to the General Assembly can be referenced on the Department's dental website at www.dmas.virginia.gov.

2.3 The Department's Dental Advisory Committee

One of the major developments in 1998 was the formation of a Dental Advisory Committee (DAC). The DAC has is made up of 20 dental providers from across the state, and includes representation from the Virginia Dental Association, Virginia Primary Care Association, Virginia Commonwealth University School of Dentistry, the Virginia Department of Health and the Department. The DAC's membership was recently expanded to achieve better representation of minority and specialist providers and better geographic balance. The DAC meets quarterly to discuss ways to improve access to dental care for Medicaid and FAMIS children.

2.5 2004 Appropriations Act

The 2004 Appropriations Act (see Attachment IX) authorizes the Department of Medical Assistance Services to amend the Medallion II waiver to allow the Department to carve out dental services provided managed care enrollees. In addition, the Act provides that the Department shall have the authority to amend the State Plans for Titles XIX (Medical Assistance) and XXI (Family Access to Medical Insurance Security) of the Social Security Act, as required by applicable statute and regulations to provide dental services to individuals enrolled in these programs on a fee-for-service basis, and further allows the Department to outsource the administration of such dental services to an administrative services contractor.

3. NATURE AND SCOPE OF SERVICES

Initially, the most significant responsibility of the Contractor will be the development of an enhanced dental provider network. Currently, there is limited dental participation, including general dentists and specialists for Medicaid enrollees in the fee for service and managed care organization programs. The second major responsibility of the Contractor will be to develop strategies, including the development of outreach campaigns, designed to significantly increase Medicaid/FAMIS Plus and FAMIS enrollee utilization of pediatric dental services, consistent with The American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children, and with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements, as mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. (See Attachment XX of this RFP).

A Dental Benefits Administrator is being sought in an effort to meet the following overall objectives:

- To ensure Medicaid/FAMIS Plus and FAMIS clients receive high quality, appropriate, and cost-effective dental services;

- To increase the number of participating Virginia Medicaid dental providers and to ensure provider network adequacy;

- To conduct regularly scheduled outreach activities designed to educate Medicaid/FAMIS Plus and FAMIS clients about good oral hygiene, the availability and importance of receiving dental services, keeping dental appointments, and how to access dental care services;

- To increase the number of children receiving dental services;

- To reflect an understanding of, and dedication to, the special needs of a diverse Medicaid/FAMIS Plus and FAMIS population;

- To ensure that the development, implementation and administration of the dental benefits program is done in a manner that includes input by interested parties, to include but not be limited to the Virginia Medicaid Dental Advisory Committee (DAC), and the Virginia Dental Association (VDA) and the Old Dominion Dental Society; and

- To provide an effective and highly efficient operation that takes advantage of technology; reduces the administrative burden on dental providers and clients; provides for coordination of complex dental care; and, provides flexible operations that allow the State to react to program changes in a timely manner.

- To develop and implement a plan to inform dental care providers on the management of oral health conditions typically seen during pregnancy and how pregnant enrollees will be educated on the importance of nutrition, good oral health, and accessing dental care during pregnancy.

The Contractor shall perform all services under this RFP. Contractor shall comply with all applicable administrative rules and the Department's written policies and procedures, as may be amended from time to time. Copies of such rules and policies are available from the Department.

4. TECHNICAL PROPOSAL – SCOPE OF SERVICES

This section contains the technical proposal requirements for this RFP. The Offeror shall provide a detailed narrative of how it will define and perform each of the required tasks listed in this section and by cross-referencing the Offeror's proposal response to each RFP requirement. The narrative shall demonstrate that the Offeror has considered all the requirements and developed a specific approach to meeting them that will support a successful project. It is not sufficient to state that the requirements will be met. The description shall correspond to the order of the tasks described herein.

The Offeror may perform all of these processes internally or involve subcontractors for any portion. Major subcontractors shall be identified by name and by a description of the services/functions they will be performing. The prime Contractor shall be wholly responsible for the entire performance whether or not subcontractors are used.

The Contractor shall make maximum efforts to ensure minimum disruption in service to enrollees and providers and a smooth interface of any claims processing or system changes to transfer necessary information without material disruption during implementation of the program.

4.1 Enrollment and Eligibility Verification

4.1.1 Enrollment

The Department is responsible for the enrollment of enrollees in the Contractor's plan.

The Contractor shall receive and process an ASCX12 Unsolicited 271 Health Care Eligibility transaction twice a month. In addition, the contractor shall obtain access to the VAMMIS via a dedicated (i.e., non-switched) data line employing TCP/IP protocol only. This data line will go from the contractor's facility the Department's fiscal agent, First Health Services Corporation (FHSC), Innsbrook Data Center.

Eligibility and enrollment verification must be based upon VAMMIS on-line eligibility information as this represents the most up-to-date eligibility information.
Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the Contractor's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in Department policy and/or Department rules and regulations.

4.1.2 Disenrollment

The Department is responsible for the disenrollment of enrollees from the Contractor's plan. The Contractor shall not disenroll enrollees. The Contractor, may, however, provide the Department with any information it deems appropriate for Department use in making a decision regarding loss of eligibility or disenrollment of a particular enrollee. The Contractor cannot grieve disenrollment actions taken by the Department.

4.1.3 Eligibility Verification

The Contractor is expected to verify eligibility through the Contractor's access to the Department's VAMMIS. The Contractor shall be responsible for the provision of all services covered under this RFP (including but not limited to call center services, outreach, member materials, prior authorization, claims processing, etc) and resulting Contract for eligible enrollees, regardless of whether or not the enrollee is listed on either of the ASCX12 Unsolicited 271 Health Care Eligibility transaction reports sent by the Department twice monthly.

4.1.4 Dental Care Outside of Eligibility Effective Dates

Except where required by the Contractor's Contract with the Department or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any dental care provided prior to the effective date of the enrollee's Medicaid/FAMIS Plus or FAMIS eligibility begin date or prior to the begin date with the Contractor. Additionally, the Contractor shall not make payment for the cost of any dental care after the effective date of the disenrollment, except for orthodontia cases initiated prior to the date of enrollment. The Contractor shall make payment for the cost of any covered services obtained on or after 12.01 a.m. on the effective date of enrollee's Medicaid/FAMIS Plus or FAMIS eligibility begin date and on or after the begin date of the Dental Administrator Contract.

4.2 Enrollee Materials and Communications

The Contractor shall distribute various types of enrollee materials, including but not limited to handbooks, provider directories, enrollee newsletters, fact sheets, notices, or any other material necessary to provide information to enrollees as agreed upon and required by the Contract resulting from this RFP. In response to this RFP, the Contractor must submit copies and examples of materials utilized in contracts of a similar scale to the requirements outlined in this RFP.

The Offeror must provide a separate cost analysis for each of the enrollee materials identified in this Section. The Contractor may distribute additional materials and information, other than those required by this Section, to enrollees in order to promote health and/or educate enrollees. All materials sent to enrollees and enrollee communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by the Department prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this RFP. Letters sent to enrollees in response to an individual query do not require prior approval. The required enrollee materials include the following:

4.2.1 Enrollee Information

The Contractor must provide enrollee handbooks and provider listings within 30 days of enrollment.

4.2.1.a Enrollee Handbooks

Enrollee handbooks must be distributed to enrollees within thirty (30) days of enrollment and shall, at a minimum, be in accordance with all applicable requirements as described in this RFP the following guidelines. The handbooks shall include and

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- a table of contents;
- an explanation on how enrollees will be notified of enrollee specific information such as effective date of enrollment.
- a description of services covered including limitations and exclusions.
- information about preventive dental services for children under age 21 to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities.
- procedures for obtaining required services including to dental specialist providers.
- an explanation of emergency and urgent care services and procedures on how to obtain emergency services both in and out of the Contractor's service area;
- information on how to access the dental provider within required time and distance standards, and how to obtain assistance from the Contractor in locating a provider;
- appeal procedures as described in Section XXXX of the RFP;
- notice to the enrollee that in addition to the enrollee’s right to file an appeal for actions taken by the Contractor, the enrollee shall have the right to request a State Fair Hearing directly to the Department;
- written policies on enrollee rights and responsibilities.
- written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 417.436.(d);
- notice to the enrollee that it is the enrollee's responsibility to notify the Contractor and the Department agency each and every time the enrollee moves to a new address;
- the toll free telephone number for the Contractor with a statement that the enrollee may contact the plan regarding questions about the program

4.2.2 Provider Listing

The Contractor shall provide all enrollees (or heads of households), with a provider listing within thirty (30) days of initial enrollment (at the same time as the enrollee handbook), and upon request. Such list shall include current provider name, address, telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. This list shall be updated continually and made available at all times electronically and in written format.

4.2.3 Quarterly Newsletter

The Contractor shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the proper utilization of services, etc., and encourage utilization of preventive dental care services. The Contractor shall include, in the newsletter; specific articles or other specific information as described and requested by the DepartmentNot more than one hundred twenty (120) calendar days shall elapse between dissemination of this information. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the Contractor shall also submit to the Department, the final version of the newsletter and the date that the information was mailed to enrollees.

4.2.4 Prior Approval Process for Enrollee Materials

The Contractor shall submit a detailed description any materials it intends to use and a description of any activities to be held prior to implementation or use. This includes but is not limited to all policies (including confidentiality) and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, newsletters, any and all other forms of advertising as well as any other forms of public contact such as participation in health fairs and/or telemarketing scripts.

All materials submitted by the Contractor shall be accompanied by a plan that describes the Contractor's intent and procedure for the use of the materials. All written material submitted by the Contractor must be submitted on paper and electronic file media. Materials developed by a recognized entity having no association with the Contractor that are related to management of specific oral health diseases or general oral health improvement must be submitted for approval; however, an electronic file for these materials may not be required. The electronic files, when required, must be submitted in a format acceptable to the Department. Electronic files submitted in any other format than those approved by the Department cannot be processed.

The Department shall review the Contractor's materials and either approve, deny or return the plan and/or materials (with written comments) within fifteen (15) calendar days from the date of submission. Once the Department has approved materials, the Contractor shall submit one (1) electronic copy of the final product to the Department Dental Program Manager. Problems may not be evident from the materials submitted, but may become apparent upon use. The Department reserves the right to notify the Contractor to discontinue or modify materials, or activities after approval.

4.2.5 Written Material Guidelines

- All materials shall be worded at a 6^{th} grade reading level, unless the Department approves otherwise.
- All written materials shall be clearly legible with a minimum font size of 12pt. unless otherwise approved by the Department.
- All written materials shall be printed with an assurance of non-discrimination.
- The following shall not be used on communication material without the written approval of the Department:

a. The Seal of the Commonwealth of Virginia;
b. The word "free" can only be used if the service is at no cost to all enrollees.

- All documents and the enrollee materials must be translated and available in Spanish. Within ninety (90) days of notification from the Department; all vital documents must be translated and available to each Limited English Proficiency group identified by the Department that constitutes five percent (5%) of the Department population.
- All written materials shall be made available in alternative formats upon request for persons with special needs or appropriate interpretation services shall be provided by the Contractor.
- The Contractor shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees. The Contractor shall provide written notice at least thirty (30) days before the effective date of the change.
- The cost of design, printing, and distribution (including postage) of all enrollee materials shall be borne by the Contractor. The Contractor shall comply with all Federal postal regulations and requirements for mailing of all materials. Any postal fees assessed on mailings sent by the Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations shall be borne by the Contractor and at no expense to the Department.

4.2.6 Failure to Comply with Enrollee Material and Communication Requirements

All services listed in Attachment I must be provided as described and the materials must adhere to the requirements as described. Failure to comply with the communication limitations/standards contained in this RFP, including but not limited to the use of unapproved and/or disapproved processes and communication material, may result in the imposition by the Department of one or more of the following sanctions which shall remain in effect until such time as the deficiency is corrected:

i. Revocation of previously authorized communication methods;
ii. Application of sanctions as provided in Section III of this RFP.

4.3 Establish and Maintain Telephone Call Center Requirement

The Contractor shall provide and maintain a toll-free telephone call center, with a unique and dedicated toll-free telephone number, in the Richmond, Virginia area for providers and enrollees. The call center shall be available Monday through Friday, except on official State holidays as defined by the Department. The hours of operation must be at least from 8:00 a.m. to 5:30 p.m., Eastern Time. As it is anticipated that the majority of the inquiries and requests for the dental program shall be received through the call center, DMAS requires a highly effective and responsive operation.

Estimation of Present Call Volume: According to the MCOs, approximately 35,000 calls are received annually regarding dental questions. DMAS estimates an additional 20,000 calls from the current FFS Medicaid population for a total volume of about 55,000 calls per year.

The Contractor shall install, operate, monitor and support an automated call distribution system that has the capability to accept prior authorization requests via telephone, facsimile, or e-mail. The Contractor shall also maintain a backup call center in case of call overflow or malfunction in the Richmond office. The Call Center is to be utilized for the following general functions:

- Complete prior authorization decisions, handle complaints and reconsiderations and make final determinations associated with the dental program.
- Provide technical and clinical support functions for providers and enrollees who request assistance on how to complete the functions described under this RFP.
- Provide general information about the new program in response to inquiries.
- Provide assistance to enrollees in locating a participating dental provider.
- Accurately respond to questions regarding covered services.
- Handle enrollee/provider inquiries, complaints and grievances.

Communication and Language Needs: The Contractor shall ensure that the communication and language needs are addressed. This applies to all non-English speaking enrollees and is not limited to prevalent languages. The enrollee cannot be charged a fee for translator or interpreter services. The Virginia Relay service for the deaf and hard-of-hearing must be used when appropriate.

The Call Center shall provide professional, prompt, and courteous customer service. Telephone staff shall greet the caller and identify themselves by name when answering. The Contractor shall establish and maintain an adequately staffed Call Center and shall ensure that the staff treats all callers with dignity and respect the caller's right to privacy and confidentiality. The Contractor shall process all incoming telephone inquiries for dental services in a timely, responsive, and courteous manner.

The Contractor agrees to relinquish ownership of the toll-free numbers upon contract termination, at which time the Department shall take title to these telephone numbers.

The Call Center shall:

- Provide a sufficient number of properly functioning toll-free and V/TTY telephone numbers (in-state and out-of state) for enrollees, providers, and other responsible parties to call for dental care and other program initiatives and requirements as described in this RFP.
- Ensure that personnel responding to inquiries and requests are fully trained and knowledgeable about Virginia Medicaid standards and protocols.
- Have the capacity to handle all telephone calls at all times; have the upgrade ability to handle any additional call volume. Any additional staff or equipment needs will be the responsibility of the Contractor. The Contractor is responsible for adequate staffing and equipment during high peak times.
- Provide sufficient telecommunications capacity to meet the State's needs with acceptable call completion and abandonment rates as specified in the performance standards. This capacity must be scalable (both increases and decreases) to demand in the future.

- Provide Virginia **licensed dentists** during all hours of call center operation to respond to dental related questions that require clinical interventions, reconsiderations and consultation. Provide on call dental support for responses to prior authorization requests.
- Effectively manage all calls received by the automated call distributor and assign incoming calls to available staff in an efficient manner.
- Provide detailed analysis of the quantity, length, and types of calls received, the amount of time it takes to answer them initially, and the number of calls transferred.
- Measure the number of callers encountering busy signals or hanging up while on hold.
- Measure the amount of time callers are placed on hold.
- Make certain that Contractor staff are responsive, helpful, courteous and accurate when responding to inquiries, and maintain enrollee confidentiality. The Contractor will be responsible for a Quality Assurance program that shall be in place to sample calls and follow up calls to confirm the quality of responses, and caller satisfaction. The Contractor is responsible for reports on the outcomes of the Quality Assurance program, and any training required to maintain the highest level of quality.
- Design and implement a management call tracking and reporting capability including an electronic record to document a synopsis of all calls and to provide a complete record of communication to the call line from providers, enrollees, and other interested parties.
- Provide complete on-line access by the State to all computer files and databases that support the system for applicable dental programs.
- Develop, maintain, and ensure compliance with Medicaid confidentiality procedures/policies, including HIPAA requirements, within the call line department.
- Provide greeting message when necessary and educational messages approved by the Department while callers are on hold.
- Install and maintain its telephone line in a way that allows calls to be monitored by a third party for the purposes of evaluating Contractor performance with a message which informs callers that such monitoring is occurring. Call monitoring by a third party, for accuracy and quality of information, must be available at the location of the call center.
- Ensure that there is a back-up telephone system in place that will operate in the event of line trouble or other problems so that access to the call center by telephone is not disrupted.
- Ensure that telephone interpreter services are accessible via the toll-free number and that providers/enrollees will not have to hang up to access these services.
- Report and assess the busiest day by number of calls.
- Measure the number of calls in the queue at peak times.
- Provide detailed daily reports of abandonment rate, wait time, service levels, etc.
- Provide adequate staff to handle prior authorization requests received by facsimile or email.
- Provide reports on the number of prior authorizations received by facsimile or email.
- Provide TDD/TDY access to the call center.

Call Center Performance Standards

The Contractor is responsible for meeting the following performance standards and is required to provide reports demonstrating that it has performed as follows:

- The call center shall be available to respond to inquiries and prior authorization requests, except for prior written approved down time.

- The Contractor shall provide sufficient staff, facilities, and technology such that ninety-five percent (95%) of all call line inquiry attempts are answered. The total number of busy signals and abandoned calls measured against the total calls attempted shall not exceed ten percent **(10%) daily.**
- Calls must be answered within three (3) rings or fifteen (15) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The wait time in the queue should not be longer than 3 minutes for 95% of the incoming calls.
- All call line inquiries that require a call back, including general inquiries and prior authorization requests, shall be returned within twenty-four (24) hours of receipt one hundred percent (100%) of the time.

Records of wait times and abandonment rates shall be kept by the Contractor and reported to the Department weekly for the first 3 months, and if not problematic, monthly thereafter. At a minimum the report shall identify the total call volume, call type (e.g., complaint, appointment assistance, benefit inquiry, etc), call center agent name, call resolution, wait time (in seconds), and the abandonment percentage rate as further described in 2.8.9.

Because call center performance is critical to the success of this project, the Offeror shall describe in detail how it will train staff to perform their duties accurately and efficiently and how it will monitor these standards and perform corrective actions when necessary. Additionally, in response to this RFP, the Offeror shall submit call center performance data for contracts of a similar scale as outlined in this RFP.

Call Center Reporting

Call center reporting shall be provided weekly for the first three months and, if not problematic, monthly thereafter, and, at a minimum, shall include the following:

a. Total hours of daily call center access provided, and any downtime experienced.
b. Overall call volume, by type of call, including nature of inquiry and source of call. (Must provide a separate report for provider and enrollee calls.)
c. Call abandonment rate, and average time prior to abandonment, including for calls placed on hold.
d. Wait time for customer service representative and/or clinician on hold; number and percentage of calls on hold which were answered by call line staff within twenty (20) seconds, and intervals thereafter.
e. Comprehensive report on the nature of calls received, with counts of the twenty most frequent types of calls handled during the month.
f. Call volume with indication of the key types of calls being received.
g. Detailed statistics regarding enrollee or provider complaints to include but not be limted to: (1) the enrollee's inability to locate a provider within contract standards; (2) provider prior authorization and billing issues; and handling of complaints/appeals.
h. Average time required to call back providers when a call back was required.
i. Average length of calls handled.
j. Outcomes of quality improvement measurements.

The call center must have the capacity to track individual provider and enrollee call activity and capture important aspects covered during the call transaction. The Contractor must report individual call activity data to the Department upon request.

4.4 Staffing Requirements

4.4.1Office Location

The Contractor must maintain a physical office in Richmond, Virginia. At minimum, the following staff shall be located in the Richmond office: Project Director, and Call Center.

4.4..2 Staffing Plan

4.4.2.a The Contractor shall not have an employment, consulting or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State.

4.4.2.b The staffing for the plan covered by this RFP must be capable of fulfilling the requirements of this RFP. A single individual may not hold more than one (1) position unless otherwise specified. The minimum staff requirements are as follows:

1. A full-time administrator (Project Director), dedicated 100% to the project, specifically identified with overall responsibility for the administration of this RFP. This person shall be at the Contractor's officer level and must be approved by the Department, including upon replacement. Said designee shall be responsible for the coordination and operation of all aspects of the RFP.

2. Sufficient trained and experienced full-time support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews.

3. Sufficient trained (administrative and clinical) and experienced full-time staff who can address the unique needs of the enrollees and any participating dental provider service limitations while assuring that services are provided in the most economical manner.

4. A full-time Provider Relations Director, and regionally located provider relations staff, whose primary duties include development and implementation of the Contractor's on-going strategies to increase provider participation and to perform other necessary provider relations activities. Regional provider relations staff should be located in the following 7 areas of the state: Tidewater, Richmond,

Northern Virginia, Charlottesville, Roanoke, and at least 2 in the far southwestern region of the Commonwealth.

5. A full-time Outreach Coordinator, and regionally located outreach staff, whose primary duties include development and implementation of the Contractor's on-going strategies to increase utilization of dental services, to lead the Contractor's program for dealing with non-compliant individuals, as described in Section XX, and to perform other necessary outreach activities.

6. A dentist who is licensed by and physically located in the Commonwealth of Virginia to serve as Dental Director to oversee the Contractor's Peer Review Committee and to be responsible for the proper provision of covered services to enrollees.

7. A staff of qualified, medically trained personnel, whose primary duties are to assist in evaluating medical necessity.

8. A quality assurance coordinator to coordinate requirements described in Section XX of this RFP.

9. A person who is trained and experienced in information systems, data processing and data reporting as required to provide necessary and timely reports to the Department.

10. Sufficient trained and experienced full-time staff to maintain a toll-free Enrollee or Customer Services function to be operated during regular business hours and to be responsible for explaining the program, assisting enrollees in the selection of dental providers; assisting enrollees to make appointments and obtain services; and handling enrollee inquiries and grievances.

11. The Contractor shall appoint a staff person to be responsible for communicating with the Department regarding provider service issues. Further, the Contractor shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this RFP. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the Department's program, including but not limited to EPSDT dental, billing and other benefit related inquiries.

12. The Contractor's staffing plan must include the materials and methods used (on-going) for training staff, including the handling of telephone requests from enrollees, participating dental providers and dentists. The Contractor shall provide copies of all training materials and a description of methods used for training staff with this RFP submission and annually thereafter.

13. The Contractor shall identify in writing the name and contact information for the Project Director, Dental Director, Provider Relations Director and Outreach Coordinator. Key contact persons shall also be provided for Accounting and Finance, Prior Authorizations, Claims Processing, Information Systems, Enrollee Services, Provider Services, Appeal System Resolution, within thirty (30) days of RFP execution. The Department reserves the right to require the Contractor to select another applicant for any of these positions. Any changes in staff persons during the term of this RFP must be made in writing to the Department within 10 business days.

14. If any member of the project management team, as identified in the Contract, becomes unavailable for any reason, the Contractor shall advise the Department immediately, and shall provide an expected timeline for the re-hire. The Department reserves the right to approve rehires to project management level positions.

15. Failure to maintain the required staffing level to meet contract requirements may result in a reduction in the Department's reimbursement to the Contractor. Reductions in staffing levels may only be made with the prior approval of the Department and may result in a loss of revenue for the Contractor. The Contractor shall not maintain positions deemed nonessential for the purpose of maintaining the current reimbursement level.

4.4.2.2.c The Contractor's failure to comply with staffing requirements as described in this RFP shall result in the application of intermediate sanctions and liquidated damages as specified in Attachment III of this RFP.

4.4.3. Licensure

The Contractor is responsible for assuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of $250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and the Department may terminate this RFP for cause as described in Section III of this RFP.

4.5 Provision of Covered Benefits

The Contractor will be responsible for administering the Medicaid and FAMIS State Plan benefit package to enrollees in accordance with the terms of this RFP. The following represents a summary of the Medicaid and FAMIS State Plan covered benefits. Reference Attachment I to this RFP for a listing of services by ADA procedure code, and the Department's Dental Manual available on-line at www.dmas@virginia.gov for an all inclusive list of covered benefits, coverage criteria and guidelines.

4.5.1 Medicaid/FAMIS Plus and FAMIS Children

The Contractor shall provide or arrange for all medically necessary diagnostic, preventive, restorative, and surgical and orthodontic dental procedures, administered by, or under the direct supervision of, a dentist. Additionally coverage is available for orthodontics to individuals under 21 when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the enrollee attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by the Department at birth). The Contractor shall follow the Department's established coverage criteria for orthodontic procedures and shall pay at least 40% of the Department's allowable reimbursement at banding. The Contractor shall continue to provide reimbursement for orthodontic treatment quarterly or monthly up to the Department's established rate of reimbursement. Orthodontic care shall be paid in full regardless of loss of Medicaid/FAMIS Plus and FAMIS eligibility, as long as the enrollee was eligible on the date of banding. Coverage criteria and guidelines are detailed in the Department's Dental Manual available on-line at www.dmas@virginia.gov.

4.5.2 Limited Medically Necessary Oral Surgery for Adults

Limited medically necessary oral surgery coverage is available for enrollees 21 years of age and older when performed by a participating dentist and only when the service is one that is either generally covered under Medicare and/or is medically necessary. Examples of medically related covered services for adults include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses complicating a medical condition or contributing to poor general health.

4.5.3 Pregnancy and Oral Health

There is currently a greater focus on the oral health of pregnant women as evidence has shown that periodontal disease may be associated with preterm, low birth weight (LBW) babies. The Offeror shall provide to the Department a plan indicating how dental care providers will be informed on the management of oral health conditions typically seen during pregnancy and how outreach to pregnant enrollees (under age 21) will be performed to educate enrollees on the importance of nutrition, good oral health, and accessing dental care during pregnancy.

Additionally, in March 2004, through Executive Directive 2, Governor Warner created the Governor's Working Group on Rural Obstetrical Care. One of the recommendations of the Working Group includes coverage provisions for outreach and dental services for all pregnant women. Coverage for this benefit has not been approved by the Governor or the General Assembly. If approved by both the Governor and the General Assembly, the Contractor shall perform outreach and administer the dental benefit for all pregnant women. As part of this RFP, the Offeror shall prepare a completely separate proposal in terms of services and cost, to provide outreach, education, and access to dental services for pregnant women age 21 and over. In the instance where the Offeror's service proposal for pregnant women is the same as that proposed for the child/limited adult population described above, the Offeror may include a clear reference to that effect. The Offeror must however include separate pricing in the cost proposal for pregnant women over age 21.

Pediatric Periodicity to Care Requirements

The Contractor shall provide pediatric dental services as medically necessary to children under the age of twenty-one, in accordance with EPSDT federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989, whether or not such services are covered under the Department's state plan and without regard to any service limits otherwise established in this RFP. This requirement shall be met by either direct provision of the service by the Contractor or by referral in accordance with 42 CFR 441.61.

Pediatric dental utilization shall be in accordance with The American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children, and EPSDT Guidelines for dental, as detailed in Attachment II to this RFP.

4.5.5 Coordination of Transportation Services

Non-emergency transportation to covered dental services is a covered service for Medicaid/FAMIS Plus enrollees and is the responsibility of the enrollees MCO or the Department's contracted transportation vendor for Medicaid/FAMIS Plus FFS children. Non-emergency transportation is not covered for FAMIS children enrolled in a MCO. FAMIS children enrolled in the Department's FFS FAMIS program may receive transportation services through the Department's contracted transportation vendor. Should transportation to a dental service be necessary for an enrollee, the Contractor will coordinate with the MCO or the FFS Transportation Contractor to ensure that the transportation is provided. The Contractor shall submit the plan/methodology for coordination of transportation services to the Department for review/approval prior to implementation. Modifications to said plan shall be submitted to the Department prior to the effective date of the changes.

4.5.4 Medical Necessity

The determination of medical necessity shall be made on a case-by-case basis. The Contractor shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each enrollee and his/her medical history. The Contractor shall have the ability to place tentative limits on a service; however, such limits shall be exceeded when medically necessary based on a patient's individual characteristics. Any procedures used to determine medical necessity shall be approved by the Department and shall be consistent with the following definition:

4.5.5.a Services or supplies provided by an institution, physician, or other provider that are required to identify or treat an enrollee's illness, disease, or injury and which are:

i. Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, or injury;
ii. Appropriate with regard to standards of good dental practice;

iii. Not solely for the convenience of an enrollee, dentist, physician, institution or other provider;

iv. The most appropriate (in terms of cost and effectiveness) supply or level of service that can safely be provided to the enrollee and that is sufficient in amount, duration, or scope to reasonably achieve their purpose. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and

v. When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

4.5.5b The Contractor shall be responsible for determining "medical necessity" in accordance with 38.2-3418.12 of the Code of Virginia for dental services rendered in a non-dental office setting. To ensure timely access for enrollees requiring these services and efficiency to the dental providers, the Contractor shall serve as the central point of contact for the dental provider, medical facility, medical anesthesiologist, MCO, the Department, and any other required provider. Additionally, all of the following requirements must be included in the Contractor's prior approval process for these types of procedures:

i. The dental provider must submit the request for authorization directly to the Contractor.

ii. Once the Contractor has reviewed and approved the case based upon medical necessity the Contractor coordinates authorization for non-dental services (example - facility and anesthesia providers) with the Department and the MCO, within the MCO provider network.

iii. Claims related to the dental facility and anesthesia services rendered in a non-dental setting shall be handled as follows:

a. MCO Enrolees

i. If the dental provider performs the anesthesia services in a non-dental setting, all dental and anesthesia services are handled by and billed to the Dental Contractor. In such cases, facility charges shall be billed directly to the MCO.

ii. If the dental provider does not perform the anesthesia services for dental provided in a non-dental setting, the dental services are handled by and billed to the Contractor. In such cases, facility and anesthesia charges are billed directly to the MCO.

b. FFS Enrollees

i. For Medicaid/FAMIS Plus and FAMIS eligible individuals who are not enrolled in a MCO on the date of service (served by the Department's FFS program) the contractor must ensure that the facility and anesthesia and any required medical providers participate in the FFS Medicaid program.

4.5.5.c Any requests received by the Contractor for medical/oral surgical procedures such as osteotomies, fractures, lacerations, excisions of bony/soft tissue lesions, TMJ surgery and any associated diagnostic services, shall be forwarded by the Contractor to the appropriate medical coverage entity (MCO or FFS) for review, approval and payment. For MCO enrollees, the request must be forwarded using the appropriate CPT code for review/payment to the enrollee's MCO. For FFS enrollees, the request must be forwarded using the appropriate CPT code for review/payment to the Department. The Contractor shall provide notice to the requesting dental provider and the enrollee that such requests have been forwarded to the appropriate entity for medical review. The Contractor shall offer assistance to recipients and providers to assure that coordination of these benefits occur timely and efficiently. This requirement does not preclude the dental provider, when rendering a medical service, from submitting requests (using the appropriate CPT code) for medical/oral surgical treatment review directly to the MCO or to the Department.

4.6 Access to and Availability of Care

The Contractor must arrange for the provision of all dental services described as covered in this RFP. The Contractor shall maintain under contract, a statewide provider network, including general dentists and dental specialists, at geographical locations that meet the accessibility requirements outlined in this RFP.

4.6.1 Access to Care

The Contractor shall maintain a network of dental providers with a sufficient number of providers who accept new Medicaid/FAMIS Plus and FAMIS enrollees within each geographical location in the Commonwealth so that appointment waiting times do not exceed thirty (30) days for regular appointments and 24 - 48 hours for urgent care. The Offeror shall document it its proposal how it will provide access to services for urgent and emergency dental and oral conditions or injuries without requiring prior authorization.

Where there is not a participating provider within the contract access standards, the Contractor must provide care coordination services, as described in subsection XX of this RFP, to assist the enrollee in accessing timely services from the nearest participating provider available. Additionally, the Contractor must notify the Department of any variance from the network

requirements as outlined in this RFP and must provide a plan for corrective action that addresses the network deficiency and includes the requirements described in subsection XX of this RFP.

4.6.2 Provider Choice

Each enrollee shall be permitted to obtain covered services from any general dentist, pediatric dentist, or other dental specialist participating in the Contractor's network accepting new patients.

4.6.3 Referral Requirements

The Department prefers (does not require) that a patient be evaluated (and referred as appropriate) by a general or pediatric dentist before seeking orthodontic treatment services.

4.6.4 Contract Time and Distance Standards

The Contractor shall maintain under contract a network of dental providers to provide the covered services specified in Attachment I statewide. The Contractor shall make services and service locations available and accessible so that patient transport time to dental providers will not exceed thirty (30) minutes, except in rural areas where documented community standards will apply.

The Contractor must ensure that an enrollee is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from a dentist or dental specialists, unless the enrollee so chooses. An exception to this standard may be granted when the Contractor has established, through utilization data provided to the Department, that a normal pattern for securing dental care services within an area falls beyond the prescribed travel distance.

4.6.5 Appointment Standards

The Contractor must arrange to provide care according to each of the following appointment standards:

i. Appointments for emergency services as defined in Attachment V (Definitions) shall be made available immediately upon the enrollee's request.

ii. Appointments for an urgent dental condition as defined in Attachment V (Definitions) shall be made available within 24 to 48 hours of the enrollee's request.

iii. Appointments for routine dental care shall be made available within thirty (30) calendar days of the enrollee's request.

iv. Office waiting time on average shall not exceed 45 minutes.

4.6.6 Monitoring Access to Care

The Contractor must establish a system to monitor its access to care to ensure that the access standards set forth in this Contract are met. The Contractor must be prepared to demonstrate to the Department that these access standards have been met or must take corrective action when there is a failure to comply.

4.7 Outreach Activities

4.7.1 Contractor's Outreach to Increase Pediatric Dental Utilization

The Contractor shall conduct regularly scheduled outreach activities designed to inform enrollees about the availability of dental services and to significantly increase the number of children receiving services. Within 45 days of execution of this RFP, the Contractor shall submit a proposed outreach plan. The Contractor's plan shall identify the target population, service areas, specific outreach activities, schedule for completion and include copies of any material to be released to enrollees. The outreach plan shall be updated at least annually. The proposed plan and any related material is subject to approval by the Department. The Department shall have thirty (30) days to review material and provide notice of approval or notice to make changes. The cost of design, printing, and distribution (including postage) shall be borne by the Contractor. The Department may require the Contractor to coordinate its efforts with outreach projects being conducted by the Department or other state agencies. The Contractor shall submit a semi annual report to the Department identifying results of its outreach activities.

The Contractor shall comply with all Federal postal regulations and requirements for mailing of all materials. Any postal fees assessed on mailings sent by the Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations shall be borne by the Contractor and at no expense to the Department.

Failure to comply with the requirements of this Section may result in the application of intermediate sanctions or liquidated damages as provided in Attachment III of this RFP.

4.7.2 Appointment Assistance

The Contractor shall make reasonable efforts to assist enrollees in obtaining appointments for covered services, including facilitating enrollee contact with a participating dental provider to establish an appointment. Contractor shall provide special assistance to individuals calling to express their difficulty in accessing an appointment with an in-network provider. This special assistance includes following-up with the enrollee (and when necessary the dental provider) to make sure that the enrollee receives an appointment for the needed services within the contract appointment and distance standards. The Contractor shall track and report to the Department monthly the number of requests for assistance to obtain an appointment, including the service area in which the enrollee required assistance.

Where there is not a participating provider within the contract access standards, the Contractor must provide care coordination services, as described in subsection XX of this RFP, to assist the enrollee in accessing timely services from the nearest participating provider available.

Additionally, the Contractor must notify the Department of the network deficiency and must provide a plan for corrective action that addresses the network deficiency.

4.7.3 Non-compliant Enrollees

The Contractor shall establish an outreach program for dealing with individuals that are non-compliant with treatment or who miss appointments. The program, at a minimum, shall follow up with enrollees who miss appointments, and also enrollees who are not compliant with routine cleanings, follow-up treatment, or good oral hygiene practices. An outline of this program describing activities conducted to address non-compliance and methods for measuring and monitoring performance outcomes must be provided with the Offeror's proposal and also as a quarterly report by the Contractor

4.7.4 Coordination with Public Health

The Contractor will work closely and cooperatively with the State and Local Health Department(s) to accomplish the goals of their Public Health Dental Programs. Identification of eligible children with urgent dental needs as well as identification of children with unmet needs will require Contractor to arrange care for these eligible children according to the access standards identified in Section XX of this RFP. Close coordination between the Division of Dental Health of the Virginia Department of Health and the Contractor will be necessary to facilitate referral arrangements.

4.7.5 Coordination with Other Entities

The Contractor shall respond, within HIPAA confidentiality requirements, to referrals from entities, including but not limited to community services organizations, advocacy groups, dental providers, schools, health departments, local departments of social services, family members, and other interested parties, when such parties are working on behalf of the enrollee in relation to securing needed dental care for the enrollee. The Contractor's response shall at minimum include following up with the enrollee or the enrollee's responsible party in relation to the issue/need communicated by the interested party.

4.8 Network Development and Provider Relations Requirements

Medicaid and FAMIS recipients' access to dental care is highly dependent on a reliable network of dental providers who are treated respectfully for their work. The Contractor shall have an effective and efficient program for recruiting dentists to join the Contractor's provider network on an on-going basis. As described in subsection XX, the Department's Medicaid agreement shall be included as part of the Contractor's provider credentialing packet. The Contractor's recruitment program shall include strategies to address barriers to provider participation throughout the Commonwealth, but should also reflect targeted efforts for the rural areas of the Commonwealth, and for enrollees with special treatment needs. The Contractor shall report the provider recruitment activities initiated, (including what, when, where and how) to the Department on a monthly basis, and must include a network analysis reflecting recruitment/retention totals by region. The Contractor shall coordinate its efforts with the dental

provider community, including the Virginia Dental Association and the Old Dominion Dental Society.

Contractor shall educate providers to follow practice guidelines for preventive health services identified by the Department consistent with The American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children, and with EPSDT program requirements. (See Attachment XX of this RFP.) Practice guidelines for pediatric dental utilization includes timely provision of exams, cleaning, fluoride treatment, sealants and any medically necessary referral for treatment of child members.

4.8.1 Dental Services Delivery System

The Contractor shall arrange for and administer covered dental services to Medicaid/FAMIS Plus and FAMIS eligible enrollees and must ensure that its dental services delivery system will provide available, accessible and adequate numbers of dental, dental specialty providers, and appropriate locations for the provision of covered services. The Contractor shall document in their response to this RFP how this system will be established. In establishing and maintaining the network, the Contractor shall consider all of the following:

i. the anticipated Medicaid/FAMIS Plus and FAMIS enrollment;

ii. the expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Medicaid/FAMIS Plus and FAMIS population to be served;

iii. the numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;

iv. the numbers of network providers not accepting new Medicaid/FAMIS Plus and FAMIS patients;

v. the geographic location of providers and enrollees, considering distance, travel time, and the means of transportation (including public transit) ordinarily used by Medicaid/FAMIS Plus and FAMIS enrollees; and

vi. whether the location of service provision provides physical access for enrollees with disabilities.

4.8.2 Provider Network Requirements

The Contractor's network shall include the following classes of providers in numbers that are sufficient to enable Contractor to furnish services described in this RFP in accordance with the timeline, geographic and other standards described in Section XX of this RFP:

a Dentists and dental hygienists, and other recognized dental professionals who are trained in dental care and oral health and experienced in performing triage for such

care; pediatric dentists; orthodontists; periodontists; endodontists; prosthodontists; oral pathologists; and oral and maxillofacial surgeons; and

b Dentists and other health and dental professionals described above with demonstrated experience in the provision of services to children with acute and chronic medical conditions, including but not limited to cardiovascular conditions; HIV infection, developmental disability, or cancer; and

c Dental specialists and subspecialists that furnish multidisciplinary treatment of cranio-facial anomalies.

The Contractor shall include in the dental network licensed providers, who meets reasonable credentialing standards, and are willing to participate in the Department's dental program. As described in subsection XX, the Department's Medicaid agreement shall be included as part of the provider credentialing packet. The Contractor is also encouraged to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions and facilities that are needed to assure that the enrollees are able to access and receive the full continuum of treatment services and support.

4.8.3 Federally Qualified Health Clinics (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments

The Contractor is encouraged to contract with Federally Qualified Health Clinics (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments that have the capacity to deliver dental services.

4.8.4 Comprehensive Network of Dental Providers with Appropriate Demographic Placement and Specialties

The Offeror must submit the following provider network analysis report as part of its proposal package. Additionally upon implementation of the contract resulting from this executed RFP, the contractor must submit the required network analysis information on a monthly basis and annually:

i. A listing in Microsoft Excel, on diskette or CD, in a format agreed upon by the Department and the Contractor, of all enrolled providers within the Contractor's proposed network. (Letters of intent will be acceptable for purposes of this RFP). Column headings shall be those listed below:
   - Provider First name
   - Provider Last name
   - Provider type and specialty, example: General Dentist, Pediatric Dentist, Orthodontist, Endodontist, Oral Surgeon, etc. (if internal company abbreviations are used, supply a cross reference)
   - City, State, Zip of the physical office location NOT the billing/payment location
   - County (can use City/County codes as defined in Appendix F)

- Office telephone number
- Tax ID number
- Medicaid Provider Identification Number (if currently enrolled as a provider)
- Additional language abilities (other than English)
- Status of contract (letter of intent or signed contract)
- Panel limitations (accepting new Medicaid/FAMIS Plus and FAMIS enrollees, accepting current Medicaid/FAMIS Plus and FAMIS enrollees only, accepting a limited number (include specifics),etc.)

ii. Sample contracts for each provider type.

iii. A discussion of how the network will address the special needs children and pregnant women.

iv. A description of educational, outreach, training programs and any other services that are rendered by the Offerors to its providers, including any provider telephone help lines.

v. A description of claims and prior authorization processing policy and procedures, including prior authorization and claims submission options, timeframes/standards for authorization approvals and provider payment.

vi. As part of on-going network management activities, the contractor shall track provider network changes, and when possible shall capture the reasons for provider termination/disenrollment. Reasons for provider termination/disenrollment must be reflected in the Contractor's monthly and annual provider network analysis report to the Department.

4.8.5 Policy of Nondiscrimination

The Contractor shall ensure that its providers provide contract services to enrollees under this Contract at the same quality level and practice standards as provided to non-Medicaid enrollees. Additionally, the Contractor shall ensure that its network providers treat enrollees with the same level of dignity and respect as served in the Contractor's commercial products.

4.8.6 Provider Licensure, Credentialing and Certification Standards

The Contractor must demonstrate that dentists in their networks are licensed by the State and have received proper certification or training to perform dental services contracted for under this RFP. The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the Department program. The Contractor's standards for licensure and certification shall be included in its participating provider network agreements. The Contractor shall ensure that providers include any disciplinary action histories from the Virginia Board of Dentistry or any other regulatory authority.

The Contractor shall have written policies and procedures for their credentialing process. The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and enrollee satisfaction surveys. The Contractor shall perform a annual review on all subcontractors

to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this RFP and resulting contract. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. The Contractor shall submit a copy of their provider credentialing standards in the response to this RFP

4.8.7 Provider Enrollment into Medicaid

The Contractor shall ensure that as part of its credentialing process all dental providers enroll in the Virginia Medicaid program. The Contractor shall coordinate provider enrollment of dental providers into the Medicaid program with the DMAS Provider Enrollment Contractor.

4.8.8 Provider Contract Agreements

The Offeror shall submit with its proposal a complete copy of the provider agreement packet. The Contractor's final provider network agreement for participation in the Virginia Smiles program shall be consistent with all Federal and State regulations and the requirements described in this RFP. The final provider network agreement language shall be developed by the Contractor and the Department, and must be approved by the Department prior to implementation and upon any revision.

All provider agreements executed by the Contractor, and all provider agreements executed by subcontracting entities or organizations, pursuant to this RFP shall comply with HIPAA privacy and security rules and regulations as described in Section 10 of this RFP.

Provider agreements must specify that the provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served.

Provider agreements must include a provision whereby either the Contractor or the provider may terminate the provider agreement without cause within 30 days advance notice. The Contractor shall maintain an electronic copy of the provider application on file, and shall provide a copy of the application to the Department upon request.

4.8.9 Provider Termination

The Contractor or the dental provider may terminate the provider agreement without cause within 30 days advance notice. The Contractor shall provide written notice to patients of a provider within fifteen (15) calendar days from the date that the Contractor becomes aware that the provider will no longer be available to render services. Additionally, the Contractor shall provide the names of other dental providers accepting Medicaid/FAMIS Plus and FAMIS patients in the enrollee's locality. Each notice shall include all components identified in the notice template to be

developed by the Contractor and approved by the Department. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for enrollees due to illness, a provider dies, the provider moves from the service area and fails to notify the Contractor or when a provider fails credentialing, and instead shall be made aware immediately upon the Contractor becoming aware of the circumstances. (Notice shall be issued in advance of the provider termination when possible or immediately upon the Contractor becoming aware of the circumstances.)

4.8.10 Change in Provider Network Status

Upon final notification of a change in provider network status, or any variation from the requirements of this RFP, which shall be based on the requirements of this RFP, the Contractor shall immediately provide written notice to enrollees living in the affected area of change in the Contractor's network. The notice content shall be consistent with the notice template to be developed by the Contractor and approved by the Department. Additionally, the Contractor shall prepare and submit to the Department within 5 business days of identifying the network deficiency a plan of corrective action. The plan must detail the activities and associated time-lines the Contractor will employ to address the network deficiency and the assistance in locating a provider that it will provide to enrollees that reside in the locality experiencing the deficiency.

4.8.11 Notice of Provider Termination to the Department

The Contractor shall notify the Department of any provider termination and submit a template copy of the enrollee notice sent as well as an electronic listing identifying each enrollee to whom a notice was sent. The Contractor shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from the Department. If the provider initiated the termination, said notice shall include a copy of the provider's notification to the Contractor.

4.8.12 Provider Education

The Contractor shall provide continuing training for participating dental providers throughout the State. The Contractor shall hold at least two training sessions per year for each region (Tidewater, Northern Virginia, Richmond/Petersburg, Charlottesville, Roanoke, and Abingdon/Far South Western Region) in the state. The Contractor must have the ability to provide individual training and education as needed and as requested by providers. At a minimum, training shall address pediatric dental utilization, billing procedures, and other pertinent provisions of the dental program. The Contractor shall submit all training material to the Department for approval at least 60 days prior to the training session. The Department shall have fifteen (15) days to review and request changes, if necessary. If changes are requested, the Contractor must resubmit the training material within ten (10) days of receipt of the Department's comments.

The Contractor must provide documentation of all formal training activities and individualized corrective action assistance to the Department on a quarterly basis.

4.8.13 Provider Manual

The Contractor shall produce and distribute a dental program criteria manual, specific to Medicaid/FAMIS Plus and FAMIS coverage, to assist participating dental providers. The manual shall be updated annually or as needed and clearly define covered services, limitations, exclusions, and utilization management procedures including, but not limited to: prior approval requirements and special documentation requirements for treatment of enrollees. The manual shall include a detailed description of billing requirements for participating dental providers and shall contain a copy of Contractor's paper billing forms and electronic billing format. The Contractor shall produce and distribute revisions to the manual to participating providers prior to the effective date. The provider manual and any revisions thereto must be submitted to the Department for review and approval prior to distribution. Once approved by the Department, the Provider Manual and any attachments must be submitted in a PDF file to the Department for inclusion on the DMAS website, and must also be published on the Contractor's website. The Department's dental coverage criteria and guidelines are detailed in the Department's Dental Manual available on-line at www.dmas@virginia.gov.

4.8.14 Provider Reconsideration and Appeals to the Contractor

The Contractor shall have a reconsideration and appeals process in place available to providers who wish to challenge adverse decisions. This process must assure that appropriate decisions are made as promptly as possible. The Contractor must develop policies and procedures regarding the reconsideration and appeals processes. These must be reviewed and approved by the Department prior to implementation. The Contractor shall notify providers of their rights to appeal adverse decisions. The Contractor will provide DMAS with monthly reports indicating the number of grievance and appeals requests received as well as the detailed analysis and disposition.

4.8.15 Provider Appeals to DMAS

Medicaid providers also have the right to appeal adverse decisions to the Department. The Contractor must inform providers of their right to appeal to the Department.

Upon receipt of notification of an appeal by the Department, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS Contract Monitor, and the provider involved in the appeal. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. Failure to submit a complete, accurate and timely appeal summary shall result in a monetary penalty of $100 per day for each day beyond these time frames that the Contractor has not submitted a complete and accurate appeal summary, and shall also result in the Contractor being liable for any costs DMAS incurs as a result of the Contractor's noncompliance.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in a monetary penalty of $100 per day for each day that the hearing or conference is delayed, and shall also result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance.

4.9 Subcontractors

4.9.1 Legal Responsibility

The Contractor shall be responsible for the administration and management of all aspects of this RFP and the dental program covered there under. If the Contractor elects to utilize a subcontractor, the Contractor shall assure that the subcontractor shall not enter into any subsequent agreement or subcontracts for any of the work contemplated under the subcontractor for purposes of this RFP, without approval of the Contractor. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the Contractor to the Department to assure that all activities under this RFP are carried out.

4.9.2 Prior approval

All subcontracts and revisions thereto shall be approved in advance by the Department. All subcontracts shall be maintained in accordance with the applicable terms of this RFP. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to the State within 30 days of execution.

4.9.3 Claims Processing

All claims for services furnished to an enrollee filed with the Contractor must be processed by either the Contractor or by one (1) subcontractor retained by the organization for the purpose of processing claims.

4.9.4 Notice of Subcontractor Termination

When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, and how continuity of care will be maintained for the enrollees. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted providers and enrollees of the change. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Attachment III of this RFP. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

4.9.5 Notice of Approval

Approval of subcontracts shall not be considered granted unless the Department issues its approval in writing. The Department may revoke such approval if the Department determines that the subcontractors fail to meet the requirements of this RFP.

4.9.6 HIPAA Requirements

To the extent that the Contractor uses one or more subcontractors or agents to provide services under this Contract, and such subcontractors or agents receive or have access to protected health information (PHI), each such subcontractor or agent shall sign a Business Associate Agreement with the Contractor that complies with HIPAA.
The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract. The Department shall have the option to review and approve all such written agreements between the Contractor and its agents and subcontractors prior to their effectiveness.

4.10 Enrollee Grievance and Appeals to the Contractor

The Contractor shall have a grievance and appeals process in place available to Medicaid and FAMIS enrollees who wish to file a grievance or challenge adverse decisions. This process must assure that appropriate decisions are made as promptly as possible. The appeals process shall include provisions for expedited appeals within 3 working days. The Contractor must develop policies and procedures regarding the grievance and appeals processes. These must be reviewed and approved by the Department prior to implementation. The Contractor shall notify recipients of their rights to appeal adverse decisions. The Contractor will provide DMAS with monthly reports indicating the number of grievance and appeals requests received as well as the detailed analysis and disposition.

4.11 Enrollee Grievance and Appeals to DMAS

Medicaid and FAMIS Enrollees have the right to appeal adverse decisions to the Department. The Contractor must notify the recipients of their right to appeal to the Department.

Upon receipt of notification of an appeal by the Department, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS Contract Monitor, and recipient involved in the appeal. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. Failure to submit a complete, accurate and timely appeal summary shall result in a monetary penalty of $100 per day for each day beyond these time frames that the Contractor has not submitted a complete and accurate appeal summary, and shall also result in the Contractor being liable for any costs DMAS incurs as a result of the Contractor's noncompliance.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. Failure to attend or defend the Contractor's decisions

at all appeal hearings or conferences shall result in a monetary penalty of $100 per day for each day that the hearing or conference is delayed, and shall also result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance.

4.12 Quality and Utilization Management

4.12.1 Quality and Appropriateness of Care

Contractor shall prepare for the Department's approval a written description of a quality monitoring/quality improvement (QM/QI) program, a utilization review program and peer review program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of dental services. The written program shall include an outcomes measurement tool for reporting and measuring results. The plan(s) shall describe who is responsible and the role of the Contractor's Dental Director in utilization review.

In response to this RFP, the Contractor must submit QM/QI materials from contracts that are similar in scale to the requirements outlined in this RFP.

4.12.2 QM/QI Meeting Requirements

The Contractor shall provide the Department Dental Manager with ten (10) days advance notice of all regularly scheduled meetings of the Quality Monitoring/Quality Improvement Committee and Peer Review Committee. The Contractors QM/QI program shall include review of the Contractor's program for dealing with non-compliant individuals as described in subsection XX of this RFP. To the extent allowed by law, the Dental Manager of the Department, or his/her designee, may attend the QM/QI meetings at his/her option. In addition, written minutes shall be kept of all meetings of the QM/QI Committee. A copy of the written minutes for each meeting shall be forwarded to the Department.

4.12.3 Peer Review Committee

The Contractor shall establish a Provider Peer Review Committee that shall meet regularly (no less than quarterly) to review the processes and outcomes of Medicaid and FAMIS dental care provided to enrollees. Contractor will submit the names of proposed members to the Department within sixty (60) days after the execution date of this RFP. The Committee shall include at least five (5) Participating Dental Providers who file at least twenty-five (25) claims per year. The Contractor's Dental Director shall be the committee chairperson. The Department reserves the right to attend the meetings.

i. The Committee shall review and recommend appropriate remedial action for any participating dental provider who has provided poor quality of care.

ii. The Committee shall coordinate with the Department regarding imposition of any sanctions against a participating dental provider who has provided poor quality of care, including termination.

iii. The Committee shall coordinate with the Department in regard to issues involving fraud or abuse by any participating dental provider.

iv. The Committee shall review and recommend appropriate action on complaints or inquiries provided by members, participating dental providers, or other persons regarding quality of care, access or other issues related to the dental program.

4.12.4 Policies and Procedures

The Contractor shall provide annually, or more frequently as revisions occur, a written copy of its dental management policies and procedures to the Department for approval. Said policies and procedures must clearly identify any services for which the Contractor will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of a service. The Department shall have thirty (30) days to review and approve or request modifications to the policies and procedures. Should the Department not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely shall not preclude the State from requiring the Contractor to respond or modify the policy or operating guideline prospectively.

4.12.5 Standards of Care

Standards of care shall reflect published recommendations of nationally recognized authorities such as: The American Dental Association, The American Academy of Pediatric Dentistry and the American Association of Oral and Maxillofacial Surgeons. The standard of care for the community will also be recognized. Participating dental providers shall not differentiate or discriminate in the treatment of any enrollee on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status or payment source.

The Contractor shall monitor provider compliance with AAPD and EPSDT requirements related to dental care and standard dental practice. The Contractor shall work with participating dental providers to develop corrective action plans to bring participating dental providers into compliance with community dental practice standards.

4.12.6 Exceptional Quality Improvement and Utilization Management Processes

The Offeror must submit the following as part of its proposal:

i. The Offeror's proposed quality improvement plan (QIP), to include linkages with administrative areas, and a description of the QI committee and its composition.

ii. A description of provider credentialing and monitoring processes, including provider profiling reports.

iii. A description of how the Offeror's enrollee complaint and grievance process is linked to the QI program.

iv. A description of the Offeror's system to identify over- and under-utilization of enrollee services, and a description of how this system would extend to network providers.

4.12.6 Performance Reviews

The Contractor shall cooperate with any performance review conducted by the Department, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the RFP. Upon reasonable notice, the Department may conduct a performance review and audit of Contractor to determine compliance with the RFP. At any time, if the Department identifies a deficiency in performance, the Contractor will be required to develop a Corrective Action Plan to correct the deficiency including an explanation of how enrollees will continue to be served until the deficiency is corrected.

4.12.8 Care Coordination

4.12.9 RFP Transition Plan

The Contractor must submit, as part of the proposal response, a transition or continuation of coverage plan that documents how it will provide coverage to the enrollee that is under treatment for medically necessary covered dental services the day before the effective date of this RFP. The Contractor shall authorize the continuation of said services without any form of prior approval.

In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the Department's contracted MCOs and/or the Department as directed to identify enrollees for whom prior approvals were issued prior to the effective date of this RFP. To the extent that the approvals are for covered services and are within the parameters of the Department approved policies and procedures for prior approvals, the Contractor will accept and honor those prior approvals.

4.12.10Transition Management

The Contractor shall coordinate with the Department's FFS program and each of the Department's contracted MCOs to effect a smooth transition of dental care. Transition management includes coordination of care as described in 2.6.3 (below) and a process whereby dental inquiries received for dates of service on or after the RFP implementation are redirected to the Contractor.

4.12.13Coordination of Care and Enrollees with Special Needs

The Contractor shall assist enrollees in need of transitioning from one provider to another, including but not limited to instances where the provider terminates participation with the

Contractor or where the enrollee is not satisfied with the quality of care being received, especially where the course of treatment is not yet complete.

Additionally, the Contractor shall provide special assistance to providers and enrollees when the dental care the enrollee needs is dependent on the enrollee receiving services of adjunct dental or medical providers. Examples include, but are not limited to instances where a child may require anesthesia in an outpatient facility in order to receive necessary dental care, where a child in need of orthodontic services must first receive services from an oral surgeon for complex teeth extractions, or by a periodontist for gum related issues before braces can be placed. The Contractor shall assist with coordination of services for individuals that have complex dental care needs involving the services of multiple dental specialist providers.

4.12.14Prior Authorization Requests

Prior authorization requests must be accepted via multiple media, per industry standards, including but not limited to mail, fax, or phone. The Contractor shall have an authorization system in place that allows providers to fax prior authorization requests (pre-treatment plans) to the contractor for medical necessity review. The Contractor shall render a decision (approve, deny, or pend) as expeditiously as the enrollee's dental condition requires and within 2 business days of receipt. This system would not preclude the Contractor from requesting additional documentation such as x-rays if required for medical necessity review in accordance with the Department's criteria and industry standards of practice.

4.12.15Prior Approval Request Tracking

Each prior approval request processed by the Contractor will be assigned a unique number and be maintained in a database designed by the Contractor that will contain all pertinent information about the request and be available to Help Desk staff. This information will include, but will not be limited to: provider name and DMAS provider ID number, enrollee name and Medicaid/FAMIS Plus or FAMIS ID number, procedure code(s) requested, requested units/visits, requested begin and end dates, procedure code(s) authorized, authorized begin and end dates, and request disposition (approved, reduced or denied). The Contactor shall report to the Department a summary of all prior authorization activity on a monthly basis.

Present prior authorization volumes are as follows. Approximately 20,000 prior authorization requests are received annually for MCO enrollees. DMAS estimates an additional 10,000 prior authorization requests for the current FFS Medicaid population for a total volume of about 30,000 dental prior authorization requests received per year.

4.13 Claims Processing Requirements

The Contractor shall have in place an automated claims processing system capable of accepting and processing paper claims and claims submitted electronically. As part of their proposal submission, Offerors must describe its claim processes including the dental claim forms accepted from providers.

The Contractor shall process, as described herein, the provider's claims for covered benefits provided to enrollees consistent with the Department's applicable policies and procedures and the terms of this RFP. Contractor shall also participate in the Department's efforts to improve and standardize billing and payment procedures.

4.13.1. Electronic Billing System

The Contractor shall maintain an electronic data processing system for claims payment and processing and shall implement an electronic billing system for interested participating dental providers in HIPAA compliant formats. All participating dental providers should be strongly encouraged and provided the training necessary to submit their claims electronically. The Contractor or any entities acting on behalf of the Contractor shall not charge providers for filing claims electronically. Providers may engage in electronic billing services from their Practice Management Service or through a Value Added Network (VAN) at their own cost. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The Contractor shall comply at all times with all recognized standardized paper billing forms/format including, but not limited to the Dental ADA Claim form.

The Contractor shall not revise or modify the standardized form or format itself. Further, the Contractor agrees to adopt national Electronic Media Claims (EMC) standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by the Department in conjunction with appropriate workgroups.

4.13.2 HIPAA and Industry Recommendations

The Contractor shall comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements. Further, the Contractor agrees that the Department may present recommendations concerning claims billing and processing that are consistent with industry norms. The Contractor shall comply with said recommendations within sixty (60) days from notice by the Department and at no additional charge to the Department.

4.13.3 Timeliness and Accuracy of Payment

The Contractor agrees to comply with prompt pay claims processing requirements in accordance with 42 C.F.R. § 447.45. The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to enrollees (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of receipt of such claims. The Contractor shall process, and, if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered. "Pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to Contractor. "Process" means the Contractor must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. With the implementation of HIPAA requirements, this

process must be electronic. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a denied claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the Contractor shall provide a status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claims. The Contractor may charge the provider for the cost associated with the production of this report.

The Contractor shall provide to the Department a detailed claim processing report in the format reflected in Attachment XI, Dental Monthly Report. The report shall capture the Contractor's performance with timely claims processing requirements and claim adjudication status applied (paid, denied, etc.).

Failure to comply with the aforementioned claims processing requirements shall result in the Contractor being required to implement a corrective action plan and shall result in the application of liquidated damages and/or immediate sanctions as described in Attachment III of this RFP.

4.13.4 Reimbursement Rate for Dental Services

When the Department has established eligibility and the enrollee has incurred dental expenses that are covered benefits within the plan, the Contractor shall make reimbursement for the dental services at the Medicaid established fee-for-service rates. The Contractor shall not use capitation payment reimbursement methods or any type of non fee-for-service reimbursement methodology for services provided under this RFP and resulting contract. The Contractor shall require the provider to be enrolled with Virginia Medicaid prior to rendering services. The Contractor shall require that participating providers hold the enrollee harmless for covered services, including any costs above the fee-for-services rates. The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor as payment in full.

As part of their proposal submission, Offerors shall provide a description of their timely filing requirements as based upon business practices. The Contractor shall process claims received within no more than 180 days of the date of service. Additionally, the contractor shall process claims, including payments, voids, and adjustments, outside of timely filing requirements in cases of retroactive or delayed eligibility, accident cases, and as a result of delayed payment from the enrollee's primary insurance payer, as detailed in Chapter V of the Department's Dental Provider Manual. The Contractor shall maintain all claim record detail for at least 6 years from the claim adjudication date.

4.13.5 Dental Service Payments

The Contractor is not at financial risk for the provision of covered benefits to enrollees. The Contractor shall prepare checks for payment to providers on a weekly basis and shall notify the State of the amount to be paid in accordance with the terms described in Section 6 of this RFP.

Claims paid through the Contractor's MMIS will be based upon enrollment information downloaded from the U271 electronic transaction sent to the Contractor twice monthly. There could occur instances where the Contractor receives claims for eligible enrollees, per the VAMMIS, but who were not included on the U271 enrollment information sent by the Department to the Contractor. In these cases, the Contractor must pend and recycle such claims versus denying them for eligibility/enrollment reasons.

4.14 Other Coverage

4.14.1 Other Insurance Coverage

The Contractor shall reject claims that should rightly be processed by an enrollee's primary dental carrier. In addition, the system must allow for coordination of benefits in accordance with the Medicaid/FAMIS Plus "payer of last resort" rules. The Contractor is responsible for deductibles and coinsurance up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS Plus and FAMIS covered services.

4.14.2 Withholding Payments

The Contractor may not withhold payment for services provided to an enrollee if third party liability or the amount of liability cannot be determined, or third party liability payment will not be available within a reasonable time.

4.14.3 Recovery of Funds

All funds recovered from third parties must be reported to the Department and treated as offsets to claims payments.

4.15 Subrogation Recoveries

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds**.**

The Contractor shall notify the Department on a monthly basis of any enrollees identified during that past month who are discovered to have any coverage not previously reported to the Contractor by the Department, including enrollees identified as having trauma injuries. (Reference Attachment VIII for the suggested format to use when reporting potential coverage secondary to an accident.) The Contractor shall provide all claims data associated with care given to enrollees in relation to accidents/traumas, and other coverage not reflected in the Department's enrollment information.

4.16 IRS Form 1099

The Contractor shall prepare and mail Internal Revenue Service ("IRS") Form 1099 on behalf of providers who receive payments under this RFP. The Contractor shall provide a hard copy and, if requested, a magnetic tape transfer of form 1099 information to the Department for subsequent delivery to the entity responsible for reporting such Form 1099 information to the IRS.

4.17 Virginia Medicaid Management Information Systems (VAMMIS) Interface Requirements

In response to this RFP, the Offeror must demonstrate the ability to fully interface with the Virginia Medicaid Management Information System (VAMMIS) to provide encounter data and other information to the state (as required) to be used for monitoring and analysis as described in Section XX of this RFP.

4.17.1 Data Mapping

The Contractor shall complete all data mapping necessary to submit information to the Department and respond to information provided by the Department at no cost to the Department. This will consist of a cross-reference map of required VAMMIS data and Contractor system data elements and data structures. The Department will make any necessary data formats available to the Contractor. Any changes required by the Contractor shall be borne by the Contractor at no expense to the Department.

4.17.2 Enrollment Updates

The Contractor shall receive and process an ASCX12 Unsolicited 271 Health Care Eligibility transaction twice a month. For real-time eligibility data, the Contractor is expected to access the VAMMIS via a dedicated (i.e., non-switched) data line employing TCP/IP protocol only. This data line will go from the contractor's facility to our fiscal agent, First Health Services Corporation (FHSC), Innsbrook Data Center.

4.17.3 Contractor VAMMIS Interface Requirements

In addition to the data line connection from the Contractor to the fiscal agent as described in 2.11.2, the Contractor must establish all necessary interface capabilities with the Virginia Medicaid Management Information System (VAMMIS). The Department interface standard for data transfers will be via File Transfer Protocol (FTP) with 36 track compressed cartridges for backup contingency, initial file loads and the Department selected communications. The Contractor must be able to send/receive data via FTP and communicate with VAMMIS real-time through a dedicated line.

4.17.4 Connectivity to the Virginia Medicaid Management Information System (VAMMIS)

The Department will provide technical assistance to the Contractor to ensure that appropriate linkage to the VAMMIS occurs and to ensure that the Contractor purchases the appropriate equipment and software applications necessary for the VAMMIS connectivity and VAMMIS access. The Department will ensure the Contractor and their staff members have access to receive training in the use of the VAMMIS. All expenses incurred in establishing connectivity

between the Contractor and First Health Services Corporation (FHSC), shall be the responsibility of the Contractor. Contractor access to the VAMMIS will be in read-only format.

The Contractor is expected to access the VAMMIS via a dedicated (i.e., non-switched) data line employing TCP/IP protocol only. This data line will go from the Contractor's facility to First Health Services Corporation (FHSC), Innsbrook Data Center. The Contractor shall provide the data line itself, DSUs/CSUs, routers, and any other necessary DTE/DCE equipment at both ends of the line. The type and speed of the data line provided shall be adequate to meet the performance requirements of this RFP. The Contractor's network shall present only public IP addresses across the data line and may be required by FHSC to provide a public address subnet for router-to-router connection. Connection to the fiscal agent's router (winning vendor may have to provide at their cost) will be a standard serial port (i.e., no ISDN, Frame Relay, ATM, etc. specific ports). Connection across the Internet will not be allowed.

For the Contractor to interface with the new VAMMIS, the Contractor will need to acquire, install, and make operational Client Builder, TN 3270 version 6.2 runtime "fat client" (or latest) on all workstations and load any new VAMMIS GUI screen updates.

The Fiscal Agent will only provide the VAMMIS GUI screen files, which were developed using Client Builder. The Contractor will work directly with the Fiscal Agent to coordinate the install and update of the Contractor's installed base of Client Builder as each release of new VAMMIS screen updates is made available. If the Contractor already has a direct data line connection to the fiscal agent (VAMMIS), an additional data line is not necessarily required. The existing data line may be used for the requirements of this RFP provided that the combined use of the line does not adversely impact the performance requirements of this RFP. That is, the bandwidth of the current line may have to be increased at the Contractor's expense to accommodate combined usage. However, multiple connections to the fiscal agent from the same location are not desirable.

FHSC requires a Symantec appliance firewall on its end of the line for each outside connection to its data center. FHSC provides and configures the firewall and charges for the expense. In the event such a firewall is required, the Contractor will absorb the expense. The Contractor should allow sufficient time for installation, configuration, and testing of the data line and associated equipment before putting it into production.

The Contractor is expected to comply with the Health Insurance Portability and Accountability Act (HIPAA) Final Rules and Standards related to the electronic transactions of data between the Contractor and FHSC, electronic correspondence between the Contractor and The Department, and transmission within and out of the Contractor's corporate network including any ISPs. These HIPAA standards involve:

1) The Privacy of Individually Identifiable Health Information;
2) Standards for Electronic Transactions; National Standards for Employer Identifiers;
3) National Standards for Health Care Provider Identifiers; and the
4) HIPAA Privacy and Security Regulations.

The Contractor will be expected to provide the Department with a written Security Plan that describes the use of data that will be transmitted to the Department or FHSC or reside in the custody of the Contractor. FHSC may also require an executed HIPAA trading partner agreement with the Contractor.

Prior to Implementation: Remote access to VAMMIS must be operational thirty-days prior to implementation.

4.17.5 Connectivity Plan

In the Proposal, the Offeror will provide documentation of the proposed connectivity plan to include, but not be limited to, connection endpoints, bandwidth, type of line, and expected protocols and application-to-application connection details.

4.17.6 DMAS Remote Access

The Contractor shall provide DMAS remote access (read-only) to the Contractor's computer system with respect to all Virginia Medicaid/FAMIS Plus and FAMIS requirements/activities. The designated access will be located and installed at DMAS and shall allow DMAS to verify all the aforementioned elements noted in this Section. The Contractor shall provide equipment, training and access to the Contractor's computer system at no cost to the Department. Remote access to VAMMIS must be operational thirty-days prior to implementation.

4.17.7 Systems Readiness Review

The Contractor will work with the Department to ensure that the Contractor's processing system satisfies the functional and informational requirements of Virginia's dental program. The Contractor will assist the Department in the analysis and testing of the information systems, claims processing requirements, and fiscal reporting systems prior to the delivery of services. The Contractor must provide system access to allow the Department to test the Contractor's system through the Department network. The Contractor will provide any software or additional communications network required for access.

4.17.8 Data Validation Edits and Audits

The Contractor's claims processing system must perform the following validation edits and audits:

i. Prior Approval/Pre-Payment Approval - The system must determine whether a covered service requires prior approval, and if so, whether the Contractor granted approval.

ii. Valid Dates of Service - The system must assure that dates of services are valid dates, are no older than three hundred sixty five (365) days from the date of the service and are not in the future.

iii. Duplicate Claims - The system must automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate and

have override capability.

iv. Covered Service - The system must verify that a service is a valid covered service and is eligible for payment under the Department's dental benefit for that eligibility group.

v. Provider Validation - The system must approve for payment only those claims received from providers eligible to provide dental services and only to providers enrolled with Medicaid/FAMIS on the date of service.

vi. Eligibility Validation – The system must confirm the enrollee for whom a service was provided was eligible on the date the service was incurred.

vii. Quantity of Service - The system must validate claims to assure that the quantity of services is consistent with the Department rules and policy.

viii. Rejected Claims - The system must determine whether a claim is acceptable for adjudication and reject claims that are not.

ix. Managed Care Organizations - The system must reject claims that should rightly be processed and paid by an enrollee's MCO for any and all physical health treatments.

x. Other Insurance Coverage – The system must reject claims that should rightly be processed by an enrollee's primary dental carrier. In addition, the system must allow for coordination of benefits in accordance with the Medicaid/FAMIS Plus "payor of last resort" rules. The Contractor is responsible for deductibles and coinsurance up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS plus and FAMIS covered services.

xi. Service Limits – The system must verify that a service is not covered outside of the Department's established service limits, including but not limited to once in a lifetime procedures.

xii. Correct Payment Amounts – The system must pay the claim at the lesser of the billed amount or the Department's allowable amount, other third party payor coverage, etc. as described in the Department's Dental Manual Chapter V.

xiii. Claims History - The Contractor must accept 24 months of paid dental claims history in an agreeable format to be used for duplicate claims payment verification purposes.

4.17.9 System Security

The Contractor will apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in an

Information Security Plan provided prior to the delivery of services. The risk analysis will also be made available to appropriate Federal agencies.

The following specific security measures should be included in the system design documentation and operating procedures:

i. Computer hardware controls that ensure acceptance of data from authorized networks only.

ii. At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes.

iii. Manual procedures that provide secure access to the system with minimal risk.

iv. Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel.

v. All Contractor MIS software changes are subject to the Department's approval prior to implementation.

vi. System operation functions must be segregated from systems development duties.

4.17.10 Disaster Preparedness and Recovery at the Automated Claims Processing Site

The Contractor must submit evidence that it has a Business Continuity/Disaster Recovery plan for its Central Processing Site. If requested, test results of the plan must be made available to the Department. The plan must be tested before the effective date of the contract and must meet the requirements of any applicable state and federal regulations, and of the Department.

The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that it meets the following requirements:

i. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The Contractor will apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue receiving calls, processing prior authorizations, claims, and other functions required in this RFP in the event that the central site is rendered inoperable. Additionally, the Contractor's disaster plan must include provisions in relation to the call center telephone number(s).

ii. Employees at the site must be familiar with the emergency procedures.

iii. Smoking must be prohibited at the site.

iv. Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel.

v. Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested.

vi. The site must be protected by an automatic fire suppression system.

vii. The site must be backed up by an uninterruptible power source system.

4.18 Electronic Data Submission Including Encounter Claims

The Contractor may not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 CFR § 142.308(d).
If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

4.18.1 Electronic Data Interchange (EDI)

The Contractor will transmit documents directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) days written notice.

The Contractor will be solely responsible for the costs of any VAN with which it contracts. The Contractor will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing or handling documents. The Contractor is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

4.18.2 Test Data Transmission

The Contractor agrees to actively send and receive test data transmissions prior to implementation until approved. The Contractor agrees to receive redundant transmission (e.g. faxed copy and electronic), if required by the Department, for up to thirty (30) days after a successful EDI link is established.

4.18.3 Garbled Transmissions

If the Contractor receives an unintelligible document/file, the Contractor will promptly notify the sending party (if identifiable from the received document/file). If the sending party is identifiable from the document but the receiving party failed to give notice that the document is unintelligible, the records of the sending party will govern. If the sending party is not identifiable from the document, the records of the party receiving the unintelligible document will govern.

4.18.4 Certification

Any payment information from the Contractor that is used for rate setting purposes (e.g. any encounter data) or any payment related data required by the state must be certified by the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor. The Contractor shall be responsible for validating submissions from providers and subcontractors.

The Contractor must use Attachment VI, Certification of Encounter Data, on a monthly basis reflecting prior submissions of encounters; and, Attachment VII, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission. Any data not certified within the specified time frames will not be considered as part of the rate setting processes.

4.18.5 Enforceability and Admissibility

Any document properly transmitted pursuant to this Agreement will be deemed for all purposes (1) to be a "writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

4.18.6 Timeliness, Accuracy, and Completeness of Data

The Contractor must ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, encounter data and provider network reports will be submitted via electronic media in accordance with Department criteria.

In the event that electronic data files are returned to the Contractor due to errors, the Contractor agrees to process incorrect data and resubmit within thirty (30) days. The Contractor agrees to correct encounter claims where appropriate and resubmit corrected encounter claims in accordance with the specifications set forth in this RFP.

4.18.7 Encounter Claims Data Submission

All encounters shall be submitted monthly using the nationally recognized formats defined below:

- Dental Claims – Submit using the American National Standards Institute (ANSI) 837, version 40.10 with addenda including all required data elements.

All encounters must be submitted to the Virginia Medicaid Management Information System (VAMMIS) Gateway System to interface with the First Health File Transfer Protocol (FTP) Server.

Submissions must be made at least monthly and may be made more frequently with the approval of the Department. Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or ISE records will be rejected and a negative 997 sent back to the submitter. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 997 will be sent back to the submitter identifying the loop. Any other ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) days of the date of rejection.

For the purposes of this Contract, an encounter is any service received by the enrollee and processed by the Contractor. The Contractor shall submit encounters/claims for all claims it receives. The Contractor is responsible for submission and validity of data from all of its subcontractors to the State or its agent in the specified format and on a timely basis.

Except for encounters involving appeals, the Contractor shall submit to the Department ALL electronic encounter claims within ninety (90) calendar days of receipt. Late data will be accepted, but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The Contractor is strongly encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require written explanations of all appeals.

Any additional costs incurred by the Department resulting from the Contractor not submitting encounters within ninety (90) calendar days of receipt will be passed on to the Contractor.

4.18.8 Encounter Data Reconciliation

The Contractor shall fully cooperate with all the Department's efforts to monitor the Contractor's compliance with the requirements of encounter data submission including encounter data accuracy, completeness, and timeliness of submission to the Department's Fiscal Agent. The Contractor shall comply with all requests related to encounter data monitoring efforts in a timely manner.

4.19 Transition Upon Termination Requirements

At the expiration of this Contract, or if at any time the Department desires a transition of all or any part of the duties and obligations of Contractor to the Department or to another vendor after termination or expiration of the Contract, the Department shall notify the Contractor of the need for transition. Such notice shall be provided at least sixty (60) days prior to the date the Contract will expire, or at the time the Department provides notice of termination to Contractor, as the case may be. The transition process will commence immediately upon such notification and

shall, at no additional cost to the Department, continue past the date of contract termination or expiration if, due to the actions or inactions of Contractor, the transition process is not completed before that date.

If delays in the transition process are due to the actions or inactions of the Department or the Department's newly designated vendor, the Department and Contractor will negotiate in good faith a contract for the conduct of and compensation for transition activities after the termination or expiration of the Contract. In the event that a subsequent Contractor is unable to assume operations on the planned date for transfer, the Contractor will continue to perform MIS operations on a month-to-month basis for up to six months beyond the planned transfer date. The Department will withhold final payment to the Contractor until transition to the new Contractor is complete.

4.19.1 Close Out and Transition Procedures:

4.19.1.a Within ten (10) business days after receipt of written notifications by the Department of the initiation of the transition, Contractor shall provide to the Department a detailed electronic document, containing the following:

i. The number of dental claims approved, denied or pending at the time of transition, including the following information: the Participant's name and identification number, the Participating Dental Provider's name and provider number, and the type of service;

ii. Information on any pending complaints, including Department appeals hearings; and

iii. The number of prior authorizations in process, including the following information: the Participant's name and identification number, the Participating dental provider name and provider number and type of dental service.

4.19.1.b Within ten (10) business days after receipt of the detailed document, the Department will provide Contractor with written instructions, which shall include, but not be limited to, the following:

i. The packaging, documentation, delivery location, and delivery date of all records, data and review information to be transferred. The delivery period shall not exceed thirty (30) days from the date the instructions are issued by the Department.

ii. The date, time and location of any transition meeting to be held among the Department, Contractor and any incoming Contractor. Contractor shall provide a minimum of two (2) individuals to attend the transition meeting and those individuals shall be

proficient in and knowledgeable about the materials to be transferred.

4.19.1.c Within five (5) business days after receipt of the materials from Contractor, the Department shall submit to Contractor in writing any questions the Department has with regard to the materials transferred by Contractor. Within five (5) business days after receipt of the questions, Contractor shall provide written answers to the Department.

4.19.1.d All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Department. On request, the Contractor shall promptly provide an acknowledgment or assignment in a tangible form satisfactory to the Department to evidence the Department's sole ownership of specifically identified intellectual property created or developed in the performance of the contract. This includes but is not limited to the call center telephone number established for Medicaid/FAMIS.

4.19.1e The Contractor shall be liable for all dental claims incurred up to the date of termination.

4.20 Reporting Requirements

4.20.1 Data Base Requirements

In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by the Department, Contractor shall maintain a current database, in a format acceptable to the Department, capable of retrieving data on short notice. At a minimum, the database shall include the following data:

Enrollee Name;
Medicaid/FAMIS Plus or FAMIS ID #;
Enrollee Social Security Number (SSN);
Enrollee MCO;
Dates of Service;
Specific service provided by procedure ADA Code;
Servicing Provider Number (Medicaid #);
Participating Dental Provider Name;
Payment Status;
Billed Charge Amount;
Allowed Amount;
Payment Amount;
Received Date;
Payment Date; and

Any other data element required by common dental practice, ADA Guidelines, federal or state law.

Data stored in the database shall be current through the prior week.

4.20.2 Claim Activity Reporting Requirements

The Contractor shall provide to the Department a Monthly Dental Report, as reflected in Attachment XI, a Detailed Monthly Claim Activity Report as described in Section XX of this RFP, a Monthly Batch Claim Operations Report, an Encounter Data Report, and a Claims Lag Triangle Report with the data elements and in the format and medium (including electronic) requested by the Department. Record layout and other information about report submission is available through the Department. The Contractor shall provide an annual version of the Network Analysis summary report reflected in Attachment XI that captures totals for the contract year, within 90 calendar days of the effective contract date and effective contract renewal date.

4.20.3 Referral Time Report

The Contractor shall submit a monthly report on the number of requests for assistance to obtain an appointment as specified in Section XX. The first report under this RFP, covering the month of June 2005, shall be due on July 15, 2005. Thereafter, reports shall be due fifteen (15) days after the end of each calendar month. The report shall provide sufficient information to allow the Department to determine the number of requests by county and the time required to locate a participating dental provider willing to serve the enrollee who is seeking an appointment for Covered Services.

4.20.4 Audited Financial Statements and Income Statements

The Contractor shall provide to the Department copies of its annual audited financial statements no later than ninety (90) days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) days after the end of each calendar quarter.

4.20.5 Outreach Reports

The Contractor shall provide an annual Outreach Report that describes the dental related outreach activities completed in the preceding year, results of those activities, lessons learned, and how future activities will be modified to incorporate lessons learned.

4.20.6 Call Center Response Time Reports

The Contractor shall maintain records and report to the Department on call wait times and abandonment rates weekly for the first 3 months, and if not problematic, monthly thereafter. At a minimum the report shall identify the total call volume, call type (e.g., complaint, appointment assistance, benefit inquiry, etc), wait time (in seconds), and the abandonment percentage rate, as

described in Section XX. Monthly reports will be due fifteen (15) days after the end of the calendar month being reported.

4.20.7 Meeting Reports

The Contractor shall submit the minutes of its Utilization Review Committee meetings, Quality Assurance Committee meetings and the Peer Review Committee meetings on a calendar quarter basis, due thirty (30) days after the end of each quarter. If no meetings occurred during the quarter, that fact shall be reported.

4.20.8 Satisfaction Surveys

The Contractor shall conduct, at a minimum, a semi-annual Enrollee Satisfaction Survey and a semi-annual Provider Satisfaction Survey. The survey questions and methodology shall be approved by the Department prior to conducting the survey. The Contractor shall submit a report identifying key findings to the Department semi-annually.

4.20.9 Public Filings

The Contractor shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this RFP.

4.20.10Comprehensive Network Analysis Report

The Contractor shall provide a Comprehensive Network Analysis Report, monthly and annually, as described in Section XX that provides a detailed analysis of provider recruitment activities and that tracks provider network changes, and when possible, that captures reasons for provider disenrollment.

4.20.11Grievance and Appeals Reports

The Contractor shall provide grievance and appeal logs and summary reports as described in Section XX of this RFP.

4.20.12Semi-Annual and Annual Report

The Contractor shall provide a semi annual and an annual report that provides a report card summary for all of the following activities: Claims Activity, Prior Authorization Activity, Network Recruitment, Enrollee Outreach, Call Center, Grievances and Appeals, Enrollee Utilization. The Offeror shall submit sample “annual report card” reports with their RFP Proposal. The Department shall approve the final reporting format. The Contractor must modify the final report to the agreed upon specifications at no cost to the Department.

4.20.13Dental Utilization Tracking System

The Contractor shall develop and maintain a tracking system with the capability to identify and report the enrollee's current dental utilization status, pending preventive services, and preventive treatment due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each enrollee.

4.20.14 Other Reporting Requirements

The Contractor shall also provide such additional monthly and ad hoc reports in relation to the RFP (and resulting contract) requirements in a format as agreed upon by the Department and the Contractor. The Department shall incur no expense in the generation of such reports. Additionally, the Contractor shall make revisions in the data elements or format of the reports required in this RFP and resulting contract upon request of the Department and without additional charge to the Department. The Department shall provide written notice of such requested revisions of format changes in a notice of required report revisions. Contractor shall maintain a data gathering and storage system sufficient to meet the requirements of this RFP. The Department may impose liquidated damages or monetary sanctions under Attachment III of the RFP based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

4.21. Virginia Bureau of Insurance Requirements

The Contractor shall demonstrate evidence of its compliance with applicable Virginia Bureau of Insurance requirements. All financial reports filed with the Department by the Contractor shall demonstrate evidence of compliance with Virginia Bureau of Insurance financial requirements.

4.22 Fraud and Abuse

4.22.1 Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

4.22.2 Fraud and Abuse Compliance Plan

a. The Contractor shall have a written Fraud and Abuse compliance plan. The Contractor's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the department with this RFP and as an annual submission as part of the Contract. The Plan must define how the Contractor will adequately identify and report suspected fraud and abuse by enrollees, by network providers, by subcontractors and by the Contractor. The Plan must be submitted annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent marketing

practices, or other types of fraud and program abuse and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

The Department shall provide notice of approval, denial, or modification to the Contractor within thirty (30) days of annual submission. The Contractor shall make any requested updates or modifications available for review after modifications are completed as requested by the Department within thirty (30) days of a request. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

   a. Claims edits;
   b. Post-payment review of claims;
   c. Provider profiling and credentialing;
   d. Prior authorization;
   e. Utilization management;
   f. Relevant subcontractor and provider agreement provisions;
   g. Written provider and enrollee material regarding fraud and abuse referrals.

v. Contain provisions for the confidential reporting by enrollees, network providers and subcontractors of plan violations to the designated person as described in item b. below;

vi. Contain provisions for the investigation and follow-up of any compliance plan reports;

vii. Ensure that the identities of individuals reporting violations of the plan are protected;

viii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

ix. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to the Department and that enrollee fraud and abuse be reported to the Department;

x. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

b. The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

c. The Contractor shall report incidents of potential or actual fraud and abuse to the Department within two (2) business days of initiation of any investigative action by the Contractor or within two (2) business days of Contractor notification that another entity is conducting such an investigation of the Contractor, its network providers, or its enrollees. All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal offices.

4.23Readiness for Implementation

No later than XXX date Contractor shall demonstrate, to the Department's satisfaction, that Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:

- That the Contractor's provider network is adequate in all regions of the Commonwealth to assure that there will be minimal disruptions in service to enrollees and that Contractor has instructed enrollees and participating dental providers in the basic operation of the Dental Program;

- That Contractor has thoroughly trained its staff on the specifics of the Dental Program policies, and that Contractor's staff has sufficient medical and dental knowledge to make determinations of dental services needs;

- That Contractor has trained its staff to handle telephone requests from enrollees, dentists and participating dental providers, and has provided to the Department copies of the materials and methods used for training and outreach;

- That Contractor has the ability to accept, process prior authorization and accept, process and pay dental claims from participating dental providers for the provision of covered services and dental services;

- That the Contractor's MIS has successfully completed the requirements listed in 2.11.7, including that the Contractor has the ability to transmit utilization data to the Department that are accurate and timely and consistent with HIPAA standards;

- That the Contractor has demonstrated the ability to submit and accept all required documentation with respect to the payments from the Department to the Contractor; and

- That the Contractor's QI, enrollee services, and other pertinent components are in place in accordance with requirements described in this RFP.

The Contractor's inability to demonstrate, to the Department's satisfaction and as provided in this Section, that Contractor is fully capable of performing all duties under this contract no later than XXX, shall be grounds for the immediate termination of the Contract by the Department pursuant to the Department Specific Terms and Conditions, XXX Termination Rights.

4.24 Implementation

Administration of the Dental Program by Contractor shall begin on XXX ("Implementation"). Payment to Contractor as provided in Section XXX Pricing/Compensation section of this Contract shall begin upon Implementation. Contractor shall not be compensated for any expenses incurred prior to implementation begin date.

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities, including any located outside of Richmond, prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

4.25 Internet Site

Contractor agrees to maintain an Internet site with a section or page devoted to enrollees and providers covered under the Virginia Medicaid/FAMIS Plus and FAMIS dental programs. As a minimum, the site shall contain the following.

i. a link to the Contractor's current provider directory with a capability to locate providers by geographic locations, type of practice, and panel restrictions (i.e., accepting or not accepting new patients)

ii. an outline of coverage

iii. other information about the plan

iv. Contractor contact names, telephone numbers, and addresses for individuals to contact with respect to services covered in this RFP

v. information regarding how to submit grievances and or appeals to the Contractor

vi. information to assist providers in relation to billing and or prior authorization issues, access to the provider manual, frequently asked questions, etc.

5. DMAS RESPONSIBILITIES

DMAS will oversee the dental program, including overall program management, determination of policy and monitoring of service. DMAS will work in partnership with the Contractor and dental providers in developing a quality program. Following are the primary responsibilities of DMAS.

a) Policy interpretation – DMAS will make the final decision regarding all policy issues
b) On-going project oversight and management to include announced and unannounced visits to ensure regulatory compliance;
c) Provide Contractors with all up to date recipient eligibility information;
d) Field observations of operations and the call center;
e) Monitoring staffing levels; outreach to recipients, provider network adequacy, pediatric dental utilization and other monitoring;
f) Review and approve any Contractor written policy, subcontracts and or procedural communications to recipients, providers and others prior to release

6. CONTRACTOR COMPENSATION

6.1 Annual Review of Controls

The Contractor shall provide to the Department and the State Treasurer a statement from its external auditor that a review of the Company's internal accounting controls reveal no conditions believed to be a material weakness in the proper administration of the Department's Dental Program in accordance with sound business principles. The written statement shall be provided annually each June 15 for the preceding calendar year.

6.2 Payment Methodology

6.2.1 Administrative Services Payments

The Contractor shall be compensated based on a fixed fee per member per month (PMPM) as determined by the RFP award and subsequent contract negotiations. Each month payment to the Contractor shall be equal to the number of enrollees certified by the Department multiplied by the administrative fee for the appropriate enrollee category (for the Department's assignment of object codes). Enrollee PMPM categories shall include Medicaid, Medicaid Expansion (enrollee aid category 94), and FAMIS enrollees under age 21, and Medicaid adults age 21 and over.

The Contractor's payment shall be based on enrollment reported by the Department to the Contractor in the Unsolicited 271 (U-271) enrollment report effective the first day of each month of the contract period. Monthly compensation will not be adjusted upward or downward during the month based on fluctuating eligibility. The Department shall arrange for payment each month at an agreed upon time by the State Treasurer's office for administrative payments as described herein.

6.2.2 Detailed Claim Processing and Reconciliation Reports

The Contractor shall pay claims only for persons determined to be eligible by the Department. The Contractor shall provide to the Department a weekly electronic Detailed Claim Processing Report. This report must provide detailed data on all claims processed, including any voids or adjustments. As part of the RFP response, the Offeror must provide sample detailed claim processing reports currently being utilized and the specific data elements captured. The final Detailed Claim Processing Report format must be approved by the Department. The Contractor must modify the final report to the agreed upon specifications at no cost to the Department.

The final report must be sorted by enrollee category (Medicaid, Medicaid Expansion, or FAMIS), and sorted by age category (Under 21, 21 and Over). The report will reflect a subtotal of claims processed by age category for each program category. The report must also reflect a grand total paid for all enrollee categories. The grand total must reconcile to the amount of reimbursement requested by the Contractor. The report must reflect claim data by individual. Individuals must be identified by name, Medicaid/FAMIS Plus or FAMIS ID number, and aid category. All payment related reports shall be submitted with the Data Certification form shown in Attachment VII.

The contractor must reconcile the net totals on the Detailed Claim Processing Report to the check register and EFT register for each weekly claim submission. This reconciliation documentation shall be provided to the Department each week. Additionally, the contractor must provide to the Department a monthly, end of month reconciliation of the checking account including a list of outstanding checks and any interest accrued from payments made by the Department for provider claims.

6.2.3 Pass-Through Payment to the Contractor for Claims Paid on Behalf of the Department

The Contractor shall provide to the Department a weekly request for reimbursement with the Detailed Claim Processing Report (where the total monies requested matches the total claim monies paid) in the agreed upon format, by enrollee category, preferably prior to the Friday evening VAMMIS payment processing cycle. The Contractor shall be reimbursed by the VAMMIS either by check or electronic funds transfer(s), as agreed to by the Contractor. For submissions received prior to the Friday VAMMIS payment processing cycle, reimbursement by check would reflect the date of the Friday occurring one week after the Friday VAMMIS payment processing cycle. Reimbursement by electronic funds transfer payment would reflect the date of the Monday occurring one week after the Friday VAMMIS payment processing cycle. For reconciliation purposes, the Contractor's payment to the provider should be dated/handled such that the funding by the Department, the Contractor's dental encounter data,

remittance advice records and checks issued would consistently represent payments processed during the same week and month.

6.2.4 Encounter Claims Submission and Reconciliation

The Contractor's encounter data shall be in the X12-410A format for dental services (reference Section XX). Encounters received shall reflect all adjudicated claims (i.e., claims paid, denied, voids, adjustments, etc.). Encounters must be submitted to the Fiscal Agent within ninety (90) days of claims processing. All fatal errors must be corrected within thirty (30) days of receipt of the error report. The Contractor shall submit the Data Certification form shown in Attachment VI within one month of the date of the encounter submission.

The encounter data must reconcile to the Detailed Claim Processing Report within six (6) months of receipt of the Detailed Claim Processing Report. Any claim reflected on the Detailed Claim Processing Report but is not validated by an encounter submission must be refunded to the Department. The Department will advise the Contractor of any discrepancies. The Contractor will have thirty (30) days to justify and correct the discrepancy or reimburse the Department of any overpayments, if any.

6.2.5 Interest Monies

Interest monies generated from the deposit of funds for provider payments shall be the property of the State. The Contractor shall report on a monthly basis any interest earned on provider payment funds to the Department. The Contractor shall refund interest payments to the Department monthly, through a repayment method to be agreed upon prior to implementation.

6.3 Travel Compensation

The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

6.4 Payment of Invoice

The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

6.5 Invoice Reductions

The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

6.6 Deductions

The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the Commonwealth of Virginia any amounts which are or shall become due and payable to the Commonwealth of Virginia by the Contractor, including but not limited to interest earned on provider payments, claims not validated in encounter submissions (as described in Section XX) and liquidated damages assessed as described in Attachment III to this RFP.

7. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

Each Offeror shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements for each proposal and the specific requirements for the Technical Proposal and the Cost Proposal.

General Requirements for Technical Proposals and Cost Proposals

7.1. Overview

Both the Technical Proposal and the Cost Proposal shall be developed and submitted in accordance with the instructions outlined in this section for each region that the Offeror wants to serve as the Contractor. The Offeror's proposals shall be prepared simply and economically, and they shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the Offeror's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks elimination from consideration if the evaluators, at their sole discretion, are unable to find where the RFP requirements are specifically addressed. Failure to provide information required by this RFP may result in rejection of the proposal.

7.1.1 Critical Elements of the Technical Proposal (will be revised for the final)

For the convenience of Offeror's, listed below are the sub-sections of Section 4 and specific requests for additional information in the proposal.

The Offeror shall provide the following:

Implementation Plan: Submit a detailed implementation plan demonstrating the Offeror's proposed schedule to implement the dental program no later than June 1, 2005. This plan must include a pre-testing of the prior authorization program with dental providers.

Implementation Schedule

The Contractor shall implement the dental program described in this RFP no later than June 1, 2005. The Contractor shall provide a detailed implementation and work plan, including deliverables and timelines, as part of the proposal. A comprehensive report on the status of each subtask, tasks, and deliverables in the work plan will be provided to the Department by the Contractor every week during implementation.

Program Operation: Submit a detailed description of the manner in which it proposes to perform the responsibilities detailed in Section ??. The plan must include a step-by-step description of the procedures by which each responsibility will be met.

Network Development: Submit a detailed description with complete information on the Contractor's dental capacity (number and types of providers in each city or county) as of the date of submission of this RFP, and the planned capacity as of the anticipated start date of the contract with DMAS. The Contractor shall submit Letters of Intent from dental providers with whom the Contractor intends to negotiate a contract for dental services prior to implementation of this RFP. Thirty days prior to the program implementation date, Contractor shall supply the Department with a final provider network for evaluation and analysis.

Education: Submit a detailed description of the Offeror's plan to educate Virginia Medicaid/FAMIS providers, and others with an interest in the dental program. The Offeror should recommend education and notification processes and methods to the Department to increase compliance rates and minimize transition disruptions. The plan must include education activities prior to and after implementation.

Prior Authorization Process: Submit a detailed description of the prior authorization approval and appeals process for dental services authorizations. The Contractor must address how it will use automation, and how the prior authorization process minimizes transactions and costs, and what specific steps will be taken to make the prior authorization process consumer/provider friendly.

Call Center: Submit a detailed description of how it will staff and operate a toll-free Call Center using a. The plan must describe the information and assistance that will be provided by Call Center Representatives.

Telecommunications System: Submit a description of a proposed system that meets the requirements of 4.3.

Staffing: The Contractor must submit a detailed description of the staffing plan, which describes the types of personnel who shall be hired to handle authorization requests, how staff shall be compensated (hourly, wage, temporary), and how the staff shall be supervised. This section shall also include a description of the Contractor's plan for staff training, including components and length of training curriculum, a plan for on-going training, and a proposal of a Training Guide or Procedures Manual.

Auditing: Submit a description of how all activities will be audited and how Call Center responses will be monitored to ensure accuracy of information provided to callers. This section must also describe a plan to ensure confidentiality of records.

❑

7.2 Binding of Proposal

The Technical Proposal shall be clearly labeled "Technical Proposal" on the front cover. The Cost Proposal shall be clearly labeled "Cost Proposal" on the front cover. The legal name of the organization submitting the proposal and the name of the region(s) (e.g., "Region 2") also shall appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2" x 11" paper with 1" margins and printed on one side only. Each copy of the Technical Proposal and each copy of the Cost Proposal and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

An Offeror submitting a Technical Proposal for multiple regions may combine in one binder the common information for all regions followed by the region-specific information, clearly identified and tabbed. Cost proposals for each region should be submitted individually.

The Offeror shall submit an original and five (5) copies of the Technical Proposal one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked "RFP 2005-01 Technical Proposal". In addition, the original of the Cost Proposal shall be sealed separately and clearly marked "RFP 2005-01" and submitted by the response date and time specified in this RFP. In addition, the original of the Cost Proposal shall be sealed separately clearly marked "RFP 2001-05 Cost Proposal" and submitted by the response date and time specified in this RFP. The Cost Proposal form in Attachment F shall be used. The Offeror shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2000 or compatible format) and of their Cost Proposal in MS Excel format (Microsoft Word 2000 or compatible format). In addition, the Offeror shall submit a redacted (proprietary and confidential information removed) electronic copy of their Technical Proposal and their Cost Proposal.

7.3 Table of Contents

The proposals shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 4: "Technical Proposal Requirements." Each section of the Technical Proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist DMAS in determining uniform compliance with specific RFP requirements.

7.4 Submission Requirements

All information requested in this RFP shall be submitted in the Offeror's proposals. An Offeror may submit proposals for more than one region. A Technical Proposal shall be submitted for each region and a Cost Proposal shall be submitted for each region. The proposals for each region will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the proposal and reasons the information should be confidential shall be stated.

Trade secrets or proprietary information submitted by an Offeror are not subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror shall invoke the protections of §2.2-4342(F) of the Code of Virginia, in writing, either before or at the time the data is submitted. The written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The proprietary or trade secret materials submitted shall be identified by some distinct method such as highlighting or underlining and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal.

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, women-owned businesses and minority-owned business shall be submitted with the Technical Proposal.

7.5 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contract agreements and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda.

At a minimum, the transmittal letter shall contain the following:

1. A statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
   a) The Offeror must identify any contracts or agreements they have with any state or local government entity that is a Medicaid and/or FAMIS provider or Contractor and the general circumstances of the contract or agreement. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest;
   b) Offeror must be able to present sufficient assurances to the state that the award of the contract to the Offeror will not create a conflict of interest between the Contractor, the Department, and its subcontractors; and

c) The Offeror must be licensed to conduct business in the state of Virginia.

2. A statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;

3. The Offeror's general information, including the address, telephone number, and facsimile transmission number;

4. Designation of an individual as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the resultant Contract;
5. A statement agreeing that the Offeror's proposal shall be valid for a minimum of 180 days from its submission to DMAS; and

6. A statement of the Offeror's intent to apply for a broker license from the VA Department of Motor Vehicles within 30 days of award.

7.6 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda, if issued, to the RFP, and submit them along with its proposal.

7.7 Procurement Contact

The principal point of contact for this procurement in DMAS shall be:

Tammy Driscoll
Manager, Health Care Services Division
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
E-mail: vasmiles@dmas.virginia.gov

All communications with DMAS regarding this RFP should be directed to the principal point of contact. All RFP content-related questions shall be in writing to the principal point of contact or the DMAS Contract Management Officer. An Offeror who communicates with any other employees or Contractors of DMAS concerning this RFP after issuance of the RFP may be disqualified from this procurement.

7.8 Submission and Acceptance of Proposals

The proposals, whether mailed or hand delivered, shall arrive at DMAS no later than 2:00 p.m. local time on Wednesday, January 5, 2005. DMAS shall be the sole determining party in

establishing the time of arrival of proposals. Late proposals shall not be accepted and shall be automatically rejected from further consideration. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:

Attention: xxx
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:

Attention: xxx
Department of Medical Assistance Services
1st Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

If DMAS does not receive at least one responsive proposal as a result of this RFP, DMAS reserves the right to select a Contractor that best meets DMAS' needs. DMAS management shall select this Contractor. DMAS also reserves the right to reject all proposals. DMAS reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Information will be posted on the DMAS web site, http://www.dmas.virginia.gov/.

7.9 Oral Presentation and Site Visit

DMAS may require one or more oral presentations by an Offeror in response to questions DMAS has about the Offeror's proposal. An oral presentation means that the Offeror is physically present in a DMAS designated meeting room. DMAS will allow a minimum five-business day advance notice to the Offeror prior to the date of the oral presentation. Expenses incurred as part of the oral presentation shall be the Offeror's responsibility.

DMAS may make one or more on-site visits to see the Offeror's operation of another dental contract, both Medicaid and non-Medicaid. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

7.10 Technical Proposal

The following describes the required format, content and sequence of presentations for the Technical Proposal:

7.10.1 Chapter One: Executive Summary

The Executive Summary Chapter shall highlight the Offeror's:

1. Understanding of the project requirements.
2. Qualifications to serve as the DMAS Contractor for the project.
3. Overall Approach to the project and a summary of the contents of the proposal.

7.10.2 Chapter Two: Corporate Qualifications and Experience

Chapter Two shall present the Offeror's qualifications and experience to serve as the Contractor for the region(s). Specifically, the Offeror shall describe its:

1. Organization Status:
   a) Name of Project Director for this Virginia brokerage;
   b) Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written;
   c) Federal employer ID number;
   d) Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers);
   e) Name of the parent organization;
   f) Major business services;
   g) Legal status and whether it is a for-profit or a not-for-profit company;
   h) A list of board members and their organizational affiliations; and
   i) Any specific licenses and accreditation held by the Offeror.

2. Corporate Experience:
   a) Offeror's overall qualifications to carry out a project of this nature and scope.
   b) The Offeror shall describe the background and success of the Offeror's organization and experience in performing dental benefits management services or other human services, specifically implementing state, local or regional programs.
   c) The Offeror's knowledge of the Medicaid and FAMIS recipient populations and the communities in the region including geography, and location of medical resources.
   d) For each experience with operating, managing, brokering or contracting for the provision of dental services or other human services, the Offeror shall indicate the contract or project title, dates of performance, scope and complexity of contract, and customer references (see below).
   e) Any other related experience the Offeror feels is relevant shall be included.
   f) The Offeror shall indicate whether the Offeror has had a contract terminated for any reason within the last five years.
   g) The Offeror also shall indicate if a claim was made on a payment or performance bond. If so, the Offeror shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.

3. References:
   a) Two customers or clients who will substantiate the Offeror's qualifications and capabilities to perform the services required by the RFP.

b) Two customers or clients who can attest to the Offeror's experience with interface files for data loads.
c) Contact information for all dental benefits administrator contracts, both Medicaid and non-Medicaid, held by the Offeror at any time since January 1, 1999.

The Offeror shall complete the Reference Form in Attachment D for each reference and contract, which includes the contract name, address, telephone number, contact person, and periods of work performance.

4. Financial Stability:
The Offeror shall submit evidence of financial stability. The Offeror should submit one of the following financial reports:

a) For a publicly held corporation, a copy of the most recent three years of audited financial reports and financial statements with the name, address, and telephone number of a responsible person in the Offeror's principal financial or banking organization, or

b) For a privately held corporation, proprietorship, or partnership, financial information for the past three years, similar to that included in an annual report, to include, at a minimum, an income statement, a statement of cash flows, a balance sheet, and number of years in business, as well as the name, address, and telephone number of a contact in the Offeror's principal financial or banking organization and its auditor.

7.10.3 Chapter Three: Technical Approach

The Offeror shall fully describe how it intends to meet all of the technical proposal requirements listed in Section 4 of this RFP. DMAS does not want a "re-write" of the RFP requirements. Specifically, the Offeror shall describe in detail its proposed technical approach for each of the tasks listed in Section 4 including any staff, systems, procedures, or materials that will be used to perform these tasks. This includes how each task will be performed, what problems need to be overcome, what functions the staff will perform, and what assistance will be needed from DMAS, if any.

Note: DMAS welcomes new and innovative approaches to dental services. While fully addressing the requirements of the RFP for Chapter Three, the Offeror may also include alternate approaches for DMAS consideration.

7.10.4 Chapter Four: Cost Proposal

The Offeror shall prepare a Cost Proposal that details the expected numbers of trips and cost per trip subset by aid category utilizing Attachment I, Cost Proposal Form. A separate Cost Proposal for start-up costs shall further detail expected start-up costs, administrative expenses, and profit. Cost Proposals that vary by more than 10% above or below the point estimates provided in page

1 of Attachment E shall be rejected. Cost proposal shall be prepared for each year of the contract.

7.10.5 Chapter Five: Staffing

The proposal shall describe the following:

1. Staffing Plan: The Offeror shall provide a functional organizational chart of the proposed project structure and organization, indicating the lines of authority for proposed staff directly involved in performance of this contract and relationships of the staff to each function of the organization. The staffing plan shall indicate the number of proposed FTEs by position and an estimate of hours to be committed to the project by each staff position. The plan shall also show the number of staff to be employed by the Contractor and staff to be obtained through subcontracting arrangements. Contact information must be provided for all key staff involved in the implementation and ongoing management of the program.

   Offerors must submit 2 references for each proposed key staff member, showing work for previous clients who have received similar services to those proposed by the Offeror for this contract. Each reference must include the name of contact person, address, telephone number and description of services provided.

   Information about the dental providers should not be included here.

2. Staff Qualifications and Résumés: Job descriptions for all key staff on the project including qualifications, experience and/or expertise required should be included. Resumes limited to two pages must be included for key staff. The resumes of personnel proposed must include qualifications, experience, and relevant education, professional certifications and training for the position they will fill.

3. Office Location: A description of the geographical location of the central business office, the billing office, the call center and satellite offices, if applicable, shall be included. All of these locations must be in Virginia. In addition, the hours of operation should be noted for each office as applicable to this contract.

7.10.6 Chapter Six: Project Work Plan

The proposal shall describe the following:

Work Plan and Project Management: The proposal shall include a work plan (Microsoft Project 2000 or compatible version) detailing the sequence of events and the time required to implement this project by July 1, 2005. The relationship between key staff and the specific tasks and assignments proposed to accomplish the scope of work shall also be included. A PERT, Gantt, or Bar Chart that clearly outlines the project timetable from beginning to end shall be included in the proposal. Key dates and key events relative to the project shall be

clearly described on the chart including critical path of tasks. The Offeror shall describe its management approach and how its proposed work plan will be executed.

Progress Reports: Upon award of a contract, the Contractor must prepare a written progress report every two weeks or more frequently as necessary and present this report to the Director, Division of Health Care Services or his designee. The report must include:

1. Status of major activities and tasks in relation to the Contractor's work plan, including specific tasks completed for each part of the project.
2. Target dates for completion of remaining or upcoming tasks/activities.
3. Any potential delays or problems anticipated or encountered in reaching target dates and the reason for such delays.
4. Any revisions to the overall work schedule.

7.11 RFP Schedule of Events

The following RFP Schedule of Events represents the State's maximum timeframe that shall be followed for implementation of the program.

EVENT	DATE
State Issues RFP	
Pre-Proposal Conference	
Deadline for Written Comments	
State Issues Responses to Written Comments	
Deadline for Submitting a Proposal to the Department	
Intent to Award	
Contract Signed and Approved	
Readiness Review Begins (Information Systems, Provider Network Review and Validation, QI Program, Enrollee Services and other program components)	
Implementation Date	June 1, 2005

If it becomes necessary to revise any part of this RFP, or if additional data are necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be issued to all Offerors by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. The RFP and subsequent information will be listed on the Department's website (www.dmas.virginia.gov).

8. PROPOSAL EVALUATIONS AND AWARD CRITERIA

DMAS will conduct a comprehensive, fair, and impartial evaluation of the Technical and Cost Proposals received in response to this RFP. The Evaluation Team will be responsible for the review and scoring of all proposals. This group will be responsible for the recommendation to the DMAS Director.

8.1 Evaluation of Minimum Requirements

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions shall deem the proposal non-responsive and subject to disqualification without further consideration. DMAS reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

RFP Cover Sheet: This form shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section XX, before the closing of acceptance of proposals in the number of copies specified.

Compliance: The proposal shall comply with the entire format requirements described in Section 4 and the Technical Proposal and Cost Proposal requirements described in Section 7.

Mandatory Conditions: All mandatory General and Specific Terms and Conditions contained in Sections 9 and 10 shall be accepted.

8.2 Proposal Evaluation Criteria

The broad criteria for evaluating proposals includes, but is not limited to, the elements below:

1. **Experience**
   Describe the experience of the Offeror in performing dental benefits administration services in rural and urban areas.
   - Experience of the Offeror in working with indigent populations on transportation services, particularly Medicaid and FAMIS populations
   - Experience in managing a diverse provider network.
   - Experience of the Offeror in developing productive relationships with public, private and not-for-profit community organizations regarding common transportation issues

2. **Technical Proposal**
   Demonstration in the written proposal of the Offeror's ability, facilities and capacity to provide all required services in a timely, efficient and professional manner.

- Clarity and thoroughness of the Offeror's proposal in addressing the components of the RFP and implementing them as described and on schedule.
- Proposed project management of the resources available to the Offeror for meeting the requirements of the RFP

3. **Staffing**

Describe the experience and expertise of specific staff assigned to the contract.

- Prior experience of staff with similar projects
- Qualifications of staff
- Appropriateness of the relationship between staff qualifications and assigned responsibilities

4. Quality of references

- References who clearly address the nature of the work performed by the Offeror.
- References who exhibit satisfaction with the work performed by the Offeror.
- Contacts for other contracts who exhibit satisfaction with the work performed by the Offeror.

5. Cost

The cost proposal shall be evaluated taking into consideration:

- The reasonableness of the proposal relative to the expected services to be provided; and
- The PMPM cost proposal.

For purposes of evaluation each Offeror's PMPM cost by eligibility category shall be multiplied by the average monthly enrollment for each eligibility category for the region, and a weighted average shall be calculated. The Offeror with the lowest cost proposal shall be identified, and all other Offeror's costs shall be evaluated in comparison to this price bid.

DMAS will not provide information to the Offerors on the specific weight of each these evaluation criteria until the date the proposals are due.

8.3 Award

The Department may make multiple awards as a result of this RFP. DMAS shall select the best Offeror(s) that, in its opinion, have the best proposal and shall award the contract to that Offeror.

9. GENERAL TERMS AND CONDITIONS

9.1 **VENDO**

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the

purchasing office and is accessible on the Internet at www.dgs.state.va.us/dps under "Manuals."

9.2 APPLICABLE LAWS AND COURTS:

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual.* The Contractor shall comply with all applicable federal, state and local laws, rules and regulations.

9.3 ANTI-DISCRIMINATION:

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1E).

In every contract over $10,000, the provisions in Sections 9.3.1 and 9.3.2. below apply:

9.3.1. During the performance of this contract, the Contractor agrees as follows:

a) The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.

c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

9.3.2. The Contractor will include the provisions of 9.3.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

9.4 ETHICS IN PUBLIC CONTRACTING:

By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

9.5 IMMIGRATION REFORM AND CONTROL ACT OF 1986:

By submitting their proposals, Offerors certify that they do not and will not during the performance of this contract employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

9.6 DEBARMENT STATUS: By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, state or local government from submitting bids or proposals on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

9.7 ANTITRUST:

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

9.8 MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS

Failure to submit a proposal on the official state form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

9.9 CLARIFICATION OF TERMS:

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact the buyer whose name appears on the

face of the solicitation no later 10:00 a.m. on November 29, 2004. Any revisions to the solicitation will be made only by addendum issued by the buyer.

9.10 PAYMENT:

To Prime Contractor:

a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges that are not in dispute (*Code of Virginia,* § 2.2-4363).

To Subcontractors:

a. A contractor awarded a contract under this solicitation is hereby obligated:
   (1) To pay the subcontractor(s) within seven (7) days of the contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

   (2) To notify the agency and the subcontractor(s), in writing, of the contractor's intention to withhold payment and the reason.

b. The contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier contractor performing under the primary contract. A contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

9.11 PRECEDENCE OF TERMS:

The following General Terms and Conditions: *VENDORS MANUAL,* APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

9.12 QUALIFICATIONS OF OFFERORS:

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services and/or furnish the goods contemplated therein.

9.13 TESTING AND INSPECTION:

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

9.14 ASSIGNMENT OF CONTRACT: A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

9.15 CHANGES TO THE CONTRACT: Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed

to by the parties as a part of their written agreement to modify the scope of the contract.

2. The Purchasing Agency may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed, the method of packing or shipment, and the place of delivery or installation. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Purchasing Agency a credit for any savings. Said compensation shall be determined by one of the following methods:

   a. By mutual agreement between the parties in writing; or
   b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Purchasing Agency's right to audit the Contractor's records and/or to determine the correct number of units independently; or
   c. By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Purchasing Agency with all vouchers and records of expenses incurred and savings realized. The Purchasing Agency shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Purchasing Agency within thirty (30) days from the date of receipt of the written order from the Purchasing Agency. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Purchasing Agency or with the performance of the contract generally.

9.16 <u>DEFAULT</u>:

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

9.17 <u>INSURANCE</u>:

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Offeror further certifies that the Contractor and any subcontractors will maintain these insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability: $100,000.
3. Commercial General Liability: $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: $1,000,000 per occurrence. (Only used if motor vehicle is to be used in the contract.)

9.18 ANNOUNCEMENT OF AWARD: Upon the award or the announcement of the decision to award a contract over $30,000, as a result of this solicitation, the purchasing agency will publicly post such notice on the DGS/DPS eVA web site (www.eva.state.va.us) for a minimum of 10 days.

9.19 DRUG-FREE WORKPLACE:

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "*drug-free workplace"* means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

9.20 NONDISCRIMINATION OF CONTRACTORS:

A bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

9.21 eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION:

The eVA Internet electronic procurement solution, web site portal www.eva.state.va.us, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or Offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

1. eVA Basic Vendor Registration Service: $25 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is $500 per order. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, and electronic bidding.
2. eVA Premium Vendor Registration Service: $200 Annual Fee plus a Transaction Fee of 1% per order received. The maximum transaction fee is $500 per order. The eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments, and ability to research historical procurement data, as they become available.

10. SPECIAL TERMS AND CONDITIONS

10.1 Access To Premises

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor's and subcontractors'

premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor or subcontractor's activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

10.2 Access To And Retention Of Records

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors with the security and confidentiality of records standards.

10.2.1 Access to Records

The Department, its duly authorized representatives and State and Federal auditors shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors.

The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its subcontractors.

10.2.2 Retention of Records

The Contractor shall retain all records and reports relating to this Contract for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the renewal date. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

10.3 Advertising

In the event a contract is awarded for services resulting from this proposal, no indication of such sales or services to DMAS will be used in product literature or advertising. The Contractor shall not state in any of its advertising or product literature that the

Commonwealth of Virginia or any agency or institution of the Commonwealth has purchased or uses its products or services.

10.4 Audit

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents, and/or state auditors shall have full access to and the right to examine any of said materials during said period.

10.5 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

10.6 Cancellation of Contract

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 30 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

10.6.1 Termination

This Contract may be terminated in whole or in part:

a. By the Department, for convenience, with not less than thirty (30) days prior written notice, which notice shall specify the effective date of the termination,
b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

10.6.2 Termination for Convenience

The Contractor may terminate this Contract with or without cause, upon six (6) full calendar months written notice to the Department. In addition, the Contractor may terminate the Contract by opting out of the renewal clause.

10.6.3 Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

10.6.4 Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

10.6.5 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been

terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to enrollee notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that DMAS determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid or FAMIS recipients, DMAS may terminate this contract immediately without notice.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

10.7 Remedies For Violation, Breach, Or Non-Performance Of Contract

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations the following remedies may be imposed.

10.7.1 Procedure For Contractor Noncompliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

10.7.2 Remedies Available To The Department

The Department reserves the right to employ, at the Department's sole discretion, remedies and sanctions to include payment withholds liquidated damages**,** and/or termination of the contract.

10.8 Performance and Payment Bonds

The Contractor shall deliver to DMAS executed performance and payment bonds, each in the sum four months of the estimated annual contract amount, with DMAS as obligee. The surety shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bonds have been delivered to and approved by DMAS. The payment bond shall be used to cover delinquent payments to the Contractor's providers and other vendors under contract with the Contractor up to the maximum of the full value of the bond in the event that the Contractor is unable to properly, promptly and efficiently perform the contract and/or the contract is terminated by default or bankruptcy.

10.9 Payment

The Contractor shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and operationally ready to begin work by the implementation date established by DMAS. DMAS will provide adequate prior notice of the implementation date. Upon approval of the Contractor's operational readiness and a determined start date, DMAS shall make payments as described in Section 6.

Each invoice submitted by the Contractor shall be subject to DMAS approval based on satisfactory performance of contracted services and compliance with all contract terms. The invoice shall contain the Federal tax identification number, the contract number and any other information subsequently required by DMAS.

10.10 Identification of Proposal Envelope

The signed proposal should be returned in a separate envelope or package sealed and identified as follows:

From:_____ _____

Name of Offeror Due Date /Time

_____ _____

Street or Box Number City, State, Zip Code

_____

RFP Number

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

10.11 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using agency or to failure of the using agency to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

10.12 Minority/Women Owned Businesses Subcontracting and Reporting

Where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the Contractor is encouraged to offer such business to certified minority and/or women-owned businesses. Names of firms may be available the Department of Minority Business Enterprise at www.dmbe.virginia.gov. When such business has been subcontracted to these firms and quarterly during the contract period, the Contractor agrees to furnish the purchasing office the following information: name of firm, phone number, total dollar amount subcontracted and type of product/service provided on a quarterly basis.

10.13 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that he may utilize, using his best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that he is as fully responsible for the acts and omissions of his subcontractors and of persons employed by them as he is for the acts and omissions of his own employees.

10.14 Renewal of Contract

This contract may be renewed by the Commonwealth upon written agreement of both parties for three successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the Department's maximum liability will also be effected through an

amendment to the Contract and shall be based upon rates negotiated with the Contractor for the extension period.

10.15 Confidentiality of Information

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from DMAS during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP.

10.16 HIPAA Compliance: The Contractor shall comply with all State and Federal Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations as it pertains to this agreement, and the Contractor shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the Contractor shall comply with the HIPAA regulations at no additional cost to DMAS. The Contractor will also be required to enter into a DMAS-supplied HIPAA Business Associate Agreement with DMAS to comply with the regulations protecting Health Care Data. A template of this Agreement is available on the DMAS Internet Site at http://www.dmas.virginia.gov/hpa-home.htm.

10.17 Obligation of Contractor

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel this proposal or to relief of any other nature because of its misunderstanding or lack of information.

10.18 Independent Contractor

Any Contractor awarded a contract under this RFP will be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of DMAS.

10.19 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Commonwealth. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

10.20 Subsidiary-Parent Relationship

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to DMAS. Any change in ownership will not relieve the original parent of its obligation of pledging its full resources to meet the

obligations of the contract with DMAS without the expressed written consent of the DMAS Director.

ATTACHMENT I

I. Dental and Oral Health Services Benefits

Covered Services – CD-5

I. Covered services for eligible enrollees under 21 years of age

A. Radiographic, Laboratory and Diagnostic Services

CODE	DESCRIPTION
D0120	Periodic oral evaluation
D0140	Limited oral evaluation
D0150	Comprehensive oral evaluation
D0210	Intraoral - complete series
D0220	Intraoral - periapical 1st film
D0230	Intraoral - periapical each additional
D0240	Intraoral - occlusal film
D0250	Extraoral - 1st film
D0260	Extraoral - each additional
D0270	Bitewing - single film
D0272	Bitewing - two films
D0274	Bitewing - four films
D0310	Sialography
D0320	Tmj arthrogram
D0321	Other tmj films - by report
D0330	Panoramic film
D0340	Cephalometric film
D0470	Diagnostic casts
D0473	Accession of tissue - gross, microscopic

B. Preventive Services

CODE	DESCRIPTION
D1110	Prophylaxis - adult
D1120	Prophylaxis - child
D1203	Fluoride w/o prophylaxis child
D1204	Fluoride w/o prophylaxis adult
D1351	Sealant - per tooth

C. Treatment Services

CODE	DESCRIPTION
D1510	Space maintainer - fixed - unilateral
D1515	Space maintainer - fixed - bilateral
D1520	Space maintainer - removable - unilateral

D1525	Space maintainer - removable - bilateral
D1550	Re-cementation space maintainer
D2140	Amalgam - 1 surface
D2150	Amalgam - 2 surface
D2160	Amalgam - 3 surface
D2161	Amalgam - 4+ surface
D2330	Composite - 1 surface anterior
D2331	Composite - 2 surface anterior
D2332	Composite - 3 surface anterior
D2335	Composite - 4+ surface anterior
D2390	Composite crown - anterior
D2391	Composite - 1 surface posterior
D2392	Composite - 2 surface posterior
D2393	Composite - 3 surface posterior
D2394	Composite - 4+ surface posterior
D2710	Crown - resin
D2721	Crown - resin/metal base
D2722	Crown - resin/metal noble
D2751	Crown - porc/metal base
D2752	Crown - porc/metal noble
D2791	Crown - full metal base
D2792	Crown - full metal noble
D2794	Crown - Titanium
D2915	Recement post & core
D2920	Recement crown
D2930	Crown - prefab stainless steel - primary
D2931	Crown - prefab stainless steel - permanent
D2932	Crown - prefab resin
D2933	Stainless steel crown, resin window
D2934	Stainless steel crown, esthetic coated
D2940	Sedative filling
D2951	Pin retention - per tooth
D2952	Cast post & core
D2954	Prefab post & core
D2962	Labial veneer - porcelain - lab
D3110	Pulp cap - direct
D3120	Pulp cap - indirect
D3220	Pulpotomy
D3221	Pulpal debridement - primary and permanent
D3230	Pulpal therapy - anterior primary
D3240	Pulpal therapy - posterior primary
D3310	Root canal - anterior
D3320	Root canal - bicuspid
D3330	Root canal - molar
D3351	Apexification/recalcification - initial
D3352	Apexification/recalcification - interim

D3353	Apexification/recalcification - final
D3410	Apicoectomy - anterior
D3421	Apicoectomy - bicuspid - first root
D3425	Apicoectomy - molar - first root
D3426	Apicoectomy - each additional root
D3430	Retrograde filling - per root
D4210	Gingivectomy/gingivoplasty - 4+ teeth per quad
D4211	Gingivectomy/gingivoplasty - 1 to 3 teeth per quad
D4260	Osseous surgery - 4+ teeth per quad
D4261	Osseous surgery - 1 to 3 teeth per quad
D4263	Bone replacement graft - 1st site in quad
D4264	Bone replacement graft - additional site in quad
D4270	Pedicle soft tissue graft
D4271	Free soft tissue graft
D4273	Sub epithelial tissue graft
D4320	Provisional splinting - intracoronal
D4321	Provisional splinting - extracoronal
D4341	Scaling and root planing - 4+ teeth per quad
D4342	Scaling and root planing - 1 to 3 teeth per quad
D4355	Full mouth debridement
D4910	Periodontal maintenance
D5110	Complete denture - max
D5120	Complete denture - mand
D5211	Partial denture - resin base - max
D5212	Partial denture - resin base - mand
D5213	Partial denture - metal base - max
D5214	Partial denture - metal base - mand
D5225	Max. Part. Denture - flexible base
D5226	Mand. Part. Denture - flexible base
D5281	Removable unilateral partial denture
D5410	Adjustment - complete denture - max
D5411	Adjustment - complete denture - mand
D5421	Adjustment - partial denture - max
D5422	Adjustment - partial denture - mand
D5510	Repair - complete denture base
D5520	Replace - missing/broken teeth - complete denture
D5610	Repair - partial denture base
D5620	Repair - cast framework partial denture
D5630	Repair - broken clasp partial denture
D5640	Replace - missing/broken teeth - partial denture
D5650	Add tooth - partial denture
D5660	Add clasp - partial denture
D5730	Reline- complete denture - max - chairside
D5731	Reline - complete denture - mand - chairside

D5740	Reline - partial denture - max - chairside
D5741	Reline - partial denture - mand - chairside
D5750	Reline- complete denture - max - lab
D5751	Reline - complete denture - mand - lab
D5760	Reline - partial denture - max - lab
D5761	Reline - partial denture - mand - lab
D5951	Feeding aid
D5982	Surgical stent
D5988	Surgical splint
D6205	Pontic - resin based
D6211	Pontic crown - metal base
D6212	Pontic crown - metal noble
D6214	Pontic - Titanium
D6241	Pontic crown - porc/metal base
D6242	Pontic crown - porc metal noble
D6251	Pontic crown - resin/metal base
D6545	Retainer - met for resin bonded
D6710	Crown - resin based
D6721	Crown - resin/metal base
D6722	Crown - resin/metal noble
D6751	Crown - porc/metal base
D6752	Crown - porc/metal noble
D6791	Crown - full metal base
D6792	Crown - full metal noble
D6794	Crown - Titanium
D6930	Recement bridge
D6970	Cast post & core
D6971	Cast post & core - part of bridge
D6972	Prefab post & core
D6973	Core buildup & pins
D7111	Coronal remnants - primary tooth
D7140	Extraction - erupted tooth or exposed root
D7210	Extraction - surgical
D7220	Impaction - soft tissue
D7230	Impaction - partially bony
D7240	Impaction - completely bony
D7241	Impaction - completely bony - surgical complications
D7250	Surgical removal of residual roots
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation
D7280	Surgical access of unerupted tooth
D7282	Mobilization of erupted tooth
D7283	Placement - device to aid eruption
D7285	Biopsy of oral tissue - hard

D7286	Biopsy of oral tissue - soft
D7288	Brush biopsy
D7310	Alveoloplasty w/ extractions per quad
D7311	Alveoloplasty w/ext. 1-3 teeth
D7320	Alveoloplasty w/o extractions per quad
D7321	Alveoloplasty w/o extractions 1-3 tooth spaces
D7410	Excision benign lesion - 1.25 cm
D7411	Excision benign lesion - >1.25 cm
D7412	Excision benign lesion - complicated
D7413	Excision malignant lesion - 1.25 cm
D7414	Excision malignant lesion - >1.25 cm
D7415	Excision malignant lesion - complicated
D7440	Excision malignant tumor - 1.25 cm
D7441	Excision malignant tumor - >1.25 cm
D7450	Removal odontogenic cyst/tumor - 1.25 cm
D7451	Removal odontogenic cyst/tumor - >1.25 cm
D7460	Removal nonodontogenic cyst/tumor - 1.25 cm
D7461	Removal nonodontogenic cyst/tumor - >1.25 cm
D7465	Destruction of lesion(s) by physical/chemical - by report
D7471	Removal of lateral exostosis - max or mand
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of tuberosity
D7510	Incision & drainage - intraoral
D7511	Incsion & drainage intraoral complicated
D7520	Incision & drainage - extraoral
D7521	Incision & drainage extraoral complicated
D7550	Partial ostectomy/sequestrectomy
D7560	Maxillary sinusotomy
D7610	Max - open reduction - teeth immobilized
D7620	Max - closed reduction - teeth immobilized
D7630	Mand - open reduction - teeth immobilized
D7640	Mand - closed reduction - teeth immobilized
D7650	Malar/zygo arch - open reduction
D7660	Malar/zygo arch - closed reduction
D7670	Alveolus - closed reduction - stabilization
D7671	Alveolus - open reduction - stabilization
D7680	Facial bones - complicated reduction
D7710	Max - open reduction - compound
D7720	Max - closed reduction - compound
D7730	Mand - oped reduction - compound
D7740	Mand - closed reduction - compound
D7750	Malar/zygo - open reduction - compound
D7760	Malar/zygo - closed reduction - compound
D7770	Alveolus - open reduction - stabilization - compound

D7771	Alveolus - closed reduction - stabilization - compound
D7780	Facial bones - complicated reduction
D7810	Oped reduction - dislocation
D7820	Closed reduction - dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical disectomy - w or w/o implant
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis
D7873	Arhtroscopy - surgical - lavage and lysis
D7874	Arthroscopy - surgical - disc repositioning
D7875	Arthroscopy - surgical - synovectomy
D7876	Arthroscopy - surgical - discectomy
D7877	Arthroscopy - surgical - debridement
D7880	Occlusal orthotic device - by report
D7910	Suture of small wounds - 5.0 cm
D7911	Complicated suture - 5.0 cm
D7912	Complicated suture - >5.0 cm
D7940	Osteoplasty - orthognathic
D7941	Osteoplasty - mandibular rami
D7943	Osteoplasty - mandibular rami w/ bone graft
D7944	Osteoplasty - segmented or subapical
D7945	Osteoplasty - body of mandible
D7946	Lefort I - max total
D7947	Lefort l - max segmented
D7948	Lefort ll or lefort lll w/o bone graft
D7949	Lefort ll or lefort lll w/ bone graft
D7950	Osseous, osteoperioosteal or cartilage graft - by report
D7955	Repair soft/hard tissue defect
D7960	Frenulectomy
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue - per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity
D7980	Sialolithotomy
D7981	Excision of salivary gland - by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7991	Coronoidectomy
D8020	Limited ortho - transitional
D8030	Limited ortho - adolescent
D8040	Limited ortho - adult

D8070	Ortho comprehensive - transitional
D8080	Ortho comprehensive - adolescent
D8090	Ortho comprehensive - adult
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8999	Unspecified ortho procedure - by report
D9110	Palliative treatment
D9220	Deep sedation/general anesthesia - 1st 30 min
D9221	Deep sedation/general anesthesia - each 15 min
D9230	Analgesia/anxiolysis/inhalation of nitrous oxide
D9241	I V conscious sedation/analgesia - 1st 30 min
D9248	Non-intravenous conscious sedation/analgesia
D9310	Consultation
D9420	Hospital call
D9440	Office visit after regularly scheduled hours
D9610	Therapeutic drug injection - by report
D9630	Other drugs/medications - by report
D9910	Desensitizing medicament
D9920	Behavior management - by report
D9930	Treatment of complications - post surgical - by report
D9999	Unspecified procedure - by report

II.	Covered services for eligible adults (age 21and older) - if medically necessary
D0140	Limited oral evaluation
D0150	Comprehensive oral evaluation
D0210	Intraoral - complete series
D0220	Intraoral - periapical 1st film
D0230	Intraoral - periapical each additional
D0240	Intraoral - occlusal film
D0250	Extraoral - 1st film
D0260	Extraoral - each additional
D0310	Sialography
D0320	Tmj arthrogram
D0321	Other tmj films - by report
D0330	Panoramic film
D0340	Cephalometric film
D4210	Gingivectomy/gingivoplasty - 4+ teeth per quad
D7140	Extraction - erupted tooth or exposed root
D7210	Extraction - surgical
D7220	Impaction - soft tissue
D7230	Impaction - partially bony
D7240	Impaction - completely bony
D7241	Impaction - completely bony - surgical complications

D7250	Surgical removal of residual roots
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7285	Biopsy of oral tissue - hard
D7286	Biopsy of oral tissue - soft
D7288	Brush biopsy
D7310	Alveoloplasty w/ extractions per quad
D7311	Alveoloplasty w/ extractions 1-3 teeth
D7320	Alveoloplasty w/o extractions per quad
D7321	Alveoloplasty w/o extractions 1-3 tooth spaces
D7410	Excision benign lesion - 1.25 cm
D7411	Excision benign lesion - >1.25 cm
D7412	Excision benign lesion - complicated
D7413	Excision malignant lesion - 1.25 cm
D7414	Excision malignant lesion - >1.25 cm
D7415	Excision malignant lesion - complicated
D7440	Excision malignant tumor - 1.25 cm
D7441	Excision malignant tumor - >1.25 cm
D7450	Removal odontogenic cyst/tumor - 1.25 cm
D7451	Removal odontogenic cyst/tumor - >1.25 cm
D7460	Removal nonodontogenic cyst/tumor - 1.25 cm
D7461	Removal nonodontogenic cyst/tumor - >1.25 cm
D7465	Destruction of lesion(s) by physical/chemical - by report
D7510	Incision & drainage - intraoral
D7511	Incision & drainage - intraoral complicated
D7520	Incision & drainage - extraoral
D7521	Incision & drainage - extraoral complicated
D7550	Partial ostectomy/sequestrectomy
D7560	Maxillary sinusotomy
D7610	Max - open reduction - teeth immobilized
D7620	Max - closed reduction - teeth immobilized
D7630	Mand - open reduction - teeth immobilized
D7640	Mand - closed reduction - teeth immobilized
D7650	Malar/zygo arch - open reduction
D7660	Malar/zygo arch - closed reduction
D7670	Alveolus - closed reduction - stabilization
D7671	Alveolus - open reduction - stabilization
D7680	Facial bones - complicated reduction
D7710	Max - open reduction - compound
D7720	Max - closed reduction - compound
D7730	Mand - oped reduction - compound
D7740	Mand - closed reduction - compound
D7750	Malar/zygo - open reduction - compound
D7760	Malar/zygo - closed reduction - compound
D7770	Alveolus - open reduction - stabilization - compound

D7771	Alveolus - closed reduction - stabilization - compound
D7780	Facial bones - complicated reduction
D7810	Oped reduction - dislocation
D7820	Closed reduction - dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical disectomy - w or w/o implant
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis
D7873	Arhtroscopy - surgical - lavage and lysis
D7874	Arthroscopy - surgical - disc repositioning
D7875	Arthroscopy - surgical - synovectomy
D7876	Arthroscopy - surgical - discectomy
D7877	Arthroscopy - surgical - debridement
D7880	Occlusal orthotic device - by report
D7910	Suture of small wounds - 5.0 cm
D7911	Complicated suture - 5.0 cm
D7912	Complicated suture - >5.0 cm
D7940	Osteoplasty - orthognathic
D7941	Osteoplasty - mandibular rami
D7943	Osteoplasty - mandibular rami w/ bone graft
D7944	Osteoplasty - segmented or subapical
D7945	Osteoplasty - body of mandible
D7946	Lefort I - max total
D7947	Lefort l - max segmented
D7948	Lefort ll or lefort lll w/o bone graft
D7949	Lefort ll or lefort lll w/ bone graft
D7950	Osseous, osteoperioosteal or cartilage graft - by report
D7955	Repair soft/hard tissue defect
D7960	Frenulectomy
D7963	Frenuloplasty
D7980	Sialolithotomy
D7981	Excision of salivary gland - by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7991	Coronoidectomy
D9220	Deep sedation/general anesthesia - 1st 30 min
D9221	Deep sedation/general anesthesia - each 15 min
D9230	Analgesia/anxiolysis/inhalation of nitrous oxide
D9241	I V conscious sedation/analgesia - 1st 30 min
D9248	Non-intravenous conscious sedation/analgesia
D9310	Consultation

D9420	Hospital call
D9610	Therapeutic drug injection - by report
D9630	Other drugs/medications - by report
D9930	Treatment of complications - post surgical - by report
D9999	Unspecified procedure - by report

ATTACHMENT II – EPSDT REQUIREMENTS

MEDICAID and EPSDT

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT enrollee even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

The EPSDT program consists of two mutually supportive, operational components:

(1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid enrollees and their parents or guardians effectively use these resources.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to seek out eligible enrollees and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the child's health needs through initial and periodic examinations and evaluations, and also to assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

Periodicity Schedule

Periodicity schedules for Periodic Screening, Vision, and Hearing services must be provided at intervals that meet reasonable standards of medical practice. States must consult with recognized medical organizations involved in child health care in developing reasonable standards.

Dental services must be provided at intervals determined to meet reasonable standards of dental practice. States must consult with recognized dental organizations involved in child health care to establish those intervals. A direct dental referral is required for every child in accordance with each states periodicity schedule and at other intervals as medically necessary. The periodicity schedule for other EPSDT services may not govern the schedule for dental services. It is expected that older children may require dental services more frequently than physical examinations.

The EPSDT benefit, in accordance with section 1905(r) of the Act, must include the following services:

Screening Services -- Screening services must include all of the following services:

- **Comprehensive health and developmental history** -- (including assessment of both physical and mental health development);

- **Comprehensive unclothed physical exam;**

- **Appropriate immunizations** -- (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines);

- **Laboratory tests** -- Identify as statewide screening requirements the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups;

  Lead Toxicity Screening - All children are considered at risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

  At this time, States may not adopt a statewide plan for screening children for lead poisoning that does not require lead screening for all Medicaid-eligible children.

- **Health Education** -- Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention;

- **Vision Services** -- At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary;

- **Dental Services** -- At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the periodicity schedule developed by the

state and at other intervals as medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial direct referral to a dentist) conform to the state periodicity schedule which must be established after consultation with recognized dental organizations involved in child health care;

"The Guide to Chidren's Dental Care in Medicaid" is now available through the CMS web site at http://www.cms.hhs.gov/medicaid/epsdt/dentalguide.pdf

- **Hearing Services** -- At a minimum, include diagnosis and treatment for defects in hearing, including hearing aids; and

- **Other Necessary Health Care** -- Provide other necessary health care, diagnosis services, treatment, and other measure described in section 1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

Diagnosis

-- When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic services. The referral should be made without delay and follow-up to make sure that the enrollee receives a complete diagnostic evaluation. If the enrollee is receiving care from a continuing care provider, diagnosis may be part of the screening and examination process. States should develop quality assurance procedures to assure comprehensive care for the individual.

Treatment -- Health care must be made available for treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services.

Lead Poisoning Prevention -- Screening for lead poisoning is a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12- and 24-months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test. Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level.

State Medicaid Agency required activities --

- States must inform all Medicaid-eligible persons under age 21 that EPSDT services are available.
- States must set distinct periodicity schedules for screening, dental, vision, and hearing services.

- States must report EPSDT performance information annually (CMS Form-416). The authority for requiring states to submit the annual report is section 1902(a)(43) of the Social Security Act (the Act). Each state must report annually for each Federal fiscal year if they administer or supervise the administration of an approved plan for a Federally aided title XIX program. The statute requires that states provide us with the following: (1) the number of children provided child health screening services, (2) the number of children referred for corrective treatment, (3) the number of children receiving dental services, and (4) the state's results in attaining goals set for the state under section 1905(r) of the Act. The form CMS-416 was developed to collect this information.

The annual EPSDT report (Form CMS-416)

The CMS-416 report provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility), who are provided child health screening services, are referred for corrective treatment, and the number receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a state's screening periodicity schedule.

Recommendations for Preventive Pediatric Dental Care

Dental services shall be provided at intervals that meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care. Dental services shall be provided at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition. Dental services must at a minimum include relief of pain and infection, restoration of teeth, and maintenance of dental health.

Federal EPSDT regulations require that States establish distinct periodicity schedules for medical, vision, hearing and dental screenings. The PCP, other screening provider or Dental Contractor must refer children three (3) years of age and older for a complete dental evaluation by a Medicaid enrolled dentist.

Referral to Dental Screening

Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

The PCP or other screening provider must make an initial direct referral to a dentist when the child receives his or her three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three (3) years and older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.

ATTACHMENT III

LIQUIDATED DAMAGES AND SANCTIONS

The Department may impose any or all of the sanctions below upon reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the RFP, provided, however, that the Department only impose those sanctions it determines to be appropriate for the deficiencies identified.

ATTACHMENT IV- CERTIFICATION OF ENCOUNTER DATA

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on encounter data submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et.al.).

The (enter name of business) has reported to Virginia for the month of (indicate month and year) all new encounters (dental). The (enter name of business) has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia in this report is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) . I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

_____

(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE)
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

ATTACHMENT V - CERTIFICATION OF DATA (NON-ENCOUNTER)

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et.al.).

The (enter name of business) has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business). I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

_____

(INDICATE NAME AND TITLE (CFO, CEO, OR DELEGATE)
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

ATTACHMENT VIII –

ACCIDENT/TRAUMA, WORKERS COMPENSATION, AND TPL COVERAGE EXCEL SPREADSHEET REPORTING FORMAT

IDENTIFIED ACCIDENT / TRAUMA CLAIM INFORMATION

ENROLLEE ID # ENROLLEE NAME BIRTHDATE PROVIDER OF SERVICE

DIAGNOSIS PROCEDURE CODE DATE OF ACCIDENT DATE OF SERVICE

AMT BILLED AMT PAID

IDENTIFIED WORKERS COMPENSATION CLAIM INFORMATION

Enrollee ID # ENROLLEE NAME BIRTHDATE PROVIDER NAME

WORK RELATED DIAGNOSIS PROCEDURE CODE DATE OF ACCIDENT

DATE OF SERVICE AMT BILLED AMT PAID

IDENTIFIED HEALTH INSURANCE INFORMATION

ENROLLEE ID # ENROLLEE NAME TPL CARRIER NAME CARRIER'S ADDRESS

COVERAGE POLICY # TPL SUBSCRIBER NAME COVERAGE EFFECTIVE DATES

ATTACHMENT IX - THE 2004 APPROPRIATIONS ACT

Item 322 # H

Language:

The Department of Medical Assistance Services shall have the authority to amend the Medallion II waiver to allow the Department to carve out dental services provided to children under the age of 21 from Medicaid managed care. In addition, the Department shall have the authority to amend the State Plans for Titles XIX and XXI of the Social Security Act, as required by applicable statute and regulations to provide dental services to children enrolled in these programs on a fee-for-service basis. The Department of Medical Assistance Services shall have the authority to enact emergency regulations under Section 2.2-4011 of the Administrative Process Act, to effect this provision. The Department of Medical Assistance Services may consider outsourcing such dental services to children under age 21 to an administrative services program.

II. ATTACHMENT XI - DENTAL MONTHLY SUMMARY REPORT (MM-CCYY)

NUMBER OF ENROLLEES	

CLAIMS VOLUME	NUMBER
MONTH BEGIN INVENTORY	
RECEIVED THIS MONTH	
PROCESSED THIS MONTH	
MONTH END INVENTORY	

CLAIMS PROCESSED	NUMBER	PERCENT
NUMBER PAID THIS MONTH		
NUMBER DENIED THIS MONTH		
NUMBER PENDED THIS MONTH		
TOTAL		0.00

PROCESSING TIME FOR CLEAN CLAIMS (I.E. PAID AND DENIED CLAIMS)	PERCENT
PERCENT PROCESSED WITHIN 30 DAYS	
PERCENT PROCESSED IN 31-90 DAYS	
PERCENT PROCESSED IN 91-365 DAYS	
PERCENT PROCESSED OVER 365 DAYS	
TOTAL	0.00

DENTAL AUTHORIZATIONS	NUMBER	PERCENT
NUMBER PENDED		
NUMBER APPROVED		
NUMBER REDUCED		
NUMBER DENIED		
TOTAL RECEIVED	0	0.00

DENTAL UTILIZATION	NUMBER	PERCENT
MEDICAID/FAMIS PLUS CHILDREN UNDER AGE 21		
FAMIS CHILDREN		
ADULTS		
TOTAL ENROLLEES SERVED	0	0.00

DENTAL PROVIDERS	NUMBER	PERCENT
NUMBER WITH OPEN PANELS		
NUMBER WITH CLOSED PANELS		
NUMBER WITH RESTRICTED PANELS		
TOTAL	0	0.00